CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

September 28, 2017
10:00 A.M.
Room 125
Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Susie Riley
Chris Carle
Peggy Roark
Julie Spivey
Eric Wright
Ashima Gupta
Steven Compton
Gary Marsh
Melody Stafford
Jay Tumbo
Stacey Watkins
William Schult
Sheila M. Currans
Teresa Aldridge
Jerry Roberts
Susan Stewart
COUNCIL MEMBERS PRESENT

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AGENDA

AGENDA
(Continued)

CHAIR PARTIN: We will get started. First of all, I'd like to welcome our new members to the Council - Melody Stafford, William Schult, Stacey Watkins, Dr. Jerry Roberts, Teresa Aldridge and Sheila Currans. Welcome.

And thank you to our outgoing members, Barry Whaley and Charlotte Whitaker.

We do have a quorum which is a first in over a year. So, even though our new members have not seen minutes from May, July, September or November of 2016 and the previous minutes from January, March, May and July of 2017, we do need to approve minutes.

So, for those of you who have looked at the minutes or maybe new members who have looked at them already, I need a motion to approve minutes.

MR. CARLE: So moved.

CHAIR PARTIN: Any second?

MR. TUMBO: Second.

CHAIR PARTIN: Jay seconded. Any discussion? All in favor, say aye. Opposed? So moved. Thank you.

MR. CARLE: We should ask for a round of applause for that.

CHAIR PARTIN: Next on the agenda is the election of a Chair, Vice-Chair and a Secretary. Again, because we have not had a quorum, we have not been able to elect a Chair or a Vice-Chair or a Secretary, and KRS 205.540 requires us to elect a Chairperson, a Vice-Chairperson and a Secretary at the first regular meeting of each fiscal year.

Now, I don't know which fiscal year we would follow; but I think since all of the members are appointed in April and, then, your terms are staggered, depending on what year you've been appointed, I think that would be a good point for us to start as far as our year.

Did you want to say something?

MS. CECIL: Well, the fiscal year it refers to is the State fiscal year. So, it's July 1.

CHAIR PARTIN: July 1. Okay. So, we can go with that.

So, what I would like to propose is that we hold an election at our next meeting, and those people who are selected will serve until the following May. And, then, we'll have another election in May and that person will serve

for a full year. Is the Council agreeable to that?

So, this will give an opportunity for the new members to get to see how the Council functions and, then, at our next meeting, we will hold an election.

If you wouldn't mind, if you are interested in serving in any of those positions, go ahead and email me after this meeting and give me your name and, then, we'll put you on the ballot for our next meeting. Yes?

DR. GUPTA: Can you maybe email us with the job descriptions of those positions?

CHAIR PARTIN: We don't have any job descriptions, but we are working on the policies.

At the last Council meeting, the Council had submitted its proposals. DMS was going to look at those proposals, offer any suggestions, bring it back to our ad hoc committee and, then, our ad hoc committee was going to make a final draft to bring before the Council for approval.

So, hopefully, those suggestions will be coming forth at this meeting. And, so, we will be able to at our November meeting offer that to the Council to approve.

So, you are shooting in the dark. You can kind of get an idea, and I'll be glad to talk to anybody about what the Chairperson does. As far as what the Vice-Chair or the Secretary does, that's kind of up in the air.

With that being said, let's move on to Old Business. The first item is Hepatitis C uniform treatment form. We were going to be able to see where the State was on that, getting that together.

DR. McKINLEY: Good morning. I'm Dr. Samantha McKinley. I'm the Pharmacy Director for Kentucky Medicaid.

DR. LIU: Good morning. Gil Liu, Chief Medical Officer, Department for Medicaid Services.

DR. McKINLEY: The last time that we spoke about Hep C, if I remember correctly, I sat here at the table and was able to tell you all that I thought it would be September before we would get the class to our P&T for a full class review. I believe that's what I said.

The Hep C class now for sure will be on the November agenda. We missed September on purpose. Any changes made by the November P&T

Committee would most likely take effect close to January.

The missing of September, again, like I said, was on purpose. We held it up to try to do some last-minute negotiations and strategies within the market and pricing baskets that we manage on behalf of our beneficiaries. It went a little bit slower than I expected. So, that's why now it will roll over to November's agenda.

However, the good news is with the current pricing proposals that we have in hand, we can now take a big leap towards those final stages of things that we've all talked about repeatedly within this category of disease states.

So, we are currently diligently moving forward and on a fast track to increase access to the class of meds as a whole for all Kentucky Medicaid beneficiaries, not just fee-for-service.

We're expanding and looking at our provider options and availability within the treatment options.

We are looking at severe reductions or complete elimination of fibrosis scores.

We're looking at our treatment

or co-treatment of opioid addiction with these drugs as well.

We're also looking to increase our treatment options that are available for our pediatric populations, and we're going to gain our alignment of these goals across all of our MCO health plan partners as we move forward.

And, so, that's kind of the update of where we are now. I'll be happy to take any questions from the committee, or, Gil, if you would like to add to any of that.

DR. LIU: Maybe I'll just see what questions there are. I think that's a very good summary, and I did want to take a moment and just welcome the new members of the Council.

MR. CARLE: One other item on the agenda that we had that we were working on was a consistent application of authorization throughout all of the MCOs, that there was a uniform approach to that as well.

DR. McKINLEY: Correct. And, so, that's the gaining the alignment piece, Chris. That's where that will come.

Right now we have the two PA forms. We have the buprenorphine form and then we

have the general form. We may end up needing, as we kind of proceed down that line, with a third form that is strictly for Hep C if we need to go that route just because of the drugs that they are.

When I think about it, we may not need that because those forms now currently cover these drugs. I don't really want to add a third form unless there's a big benefit to adding a third form because it's just one more piece of paper that everybody has to shuffle and that's no fun for anyone.

So, I would like to keep it to the two we have, but we will, in essence, sort of have common criteria. So, that will alleviate a lot of the burden of the provider trying to figure out the rotation, right, of whose MCO is in place at the moment.

MR. CARLE: And that's exactly what we were trying to accomplish. So, thank you.

DR. McKINLEY: That is not forgotten. That will accomplish.

MR. CARLE: Great. Thank you.

DR. PARTIN: Anybody else have any questions? Thank you.

And, then, next on the agenda

were the policies that I spoke of earlier.

MS. CECIL: Good morning. Veronica Cecil, Deputy Commissioner for Medicaid. And I do apologize that we have not gotten those changes back to the ad hoc committee.

We will commit to doing that in the next week. We'll get it to the ad hoc committee; and if they are comfortable with the recommendations, we will then be happy to send that out to the entire MAC for their review, if that's okay with you.

CHAIR PARTIN: Okay.

MS. CECIL: Thank you.

CHAIR PARTIN: And at our last meeting, Aetna gave a presentation and they were going to provide us with some followup information.

So, at this point in time, I would like to ask the Aetna representatives to come forward and we can go over those questions that were outstanding from the last time.

DR. HEISTAND: Dr. David Heistand. I'm Medical Director of Aetna Better Health of Kentucky. Unfortunately, I was not able to be here at the last meeting but I think I have answers to all your questions.

MS. RICHARDSON: I'm Kimberlee

Richardson, Director of Behavioral Health for Aetna.

DR. HEISTAND: The first question really harkens back to what Dr. McKinley just mentioned, treatment of Hepatitis C at fibrosis Stage 3.

We have simply mirrored the State Medicaid benefit and policy and we are in agreement. We've had extensive discussions with Dr. McKinley and Dr. Liu. We will be complying and going along with decisions that will be made with the November P&T. So, we will fall in line with what the State decides to do at that time.

CHAIR PARTIN: So, no rationale for waiting for Stage 3. It's just because somebody else does it that way, that you do it that way?

DR. HEISTAND: We are in line with the State fee-for-service schedule.

There is an extensive rationale for why a fibrosis Stage 3 has been utilized as a cut point for treatment, but I am not an expert in the field nor am I the policymaker, and, so, those discussions would be outside of my area of expertise.

CHAIR PARTIN: Okay.

DR. HEISTAND: With regard to why nurse practitioners may have been thought to be

excluded from the Quality Reward Program, I'm really not certain why that statement was made. Nurse practitioners are PCPs within the Aetna system. PCPs are included in the value-based solution agreements that we have. So, across the spectrum, nurse practitioners would roll into the larger agreements.

Individual nurse practitioners, if individuals were to wish to be a part of our PCMH as an individual of our QR programs, they're eligible for that as well.

CHAIR PARTIN: The reason the question was there is because we were told specifically that they were not included, only physicians.

DR. HEISTAND: No. They are and they are listed as PCPs. Linda Steinke who gave the presentation is retired from the organization, and I don't know if that was confusion or what but they are listed as PCPs.

Success rates for member incentive rewards, specifically the diabetic retinal exam, I have some numbers for you. I would not want to--this was not a scientific study. It's correlative data. In 2014, our HEDIS rate was about 40½%. In 2016, it was 46.6%. So, we've seen about a

6% increase that correlates with the time in which we have been giving incentives for members completing that exam. So, again, I don't think it's causative but it correlates and that's the best we can do with that. We will continue to monitor that.

You asked for data on success of decreasing ER visits. We have several programs in place. Year over year, we've seen a 9.1% decrease in ER utilization.

And, then, the final question was related to locations and dates for diabetic classes. We have just received our final certification and eligibility to complete this. Classes are being scheduled in 2018 currently. Those specific dates and times are being finalized and we can post those to the website when we've completed that.

Our goal is to offer these programs in counties that do not have ongoing programs available. So, we have received some information on counties that do not have opportunity and we will be pushing to schedule in those counties specifically.

CHAIR PARTIN: Will you be notifying the participants of your ensurance of these

classes? Will something go out?

DR. HEISTAND: Yes. Yes, they will. And, again, the classes are not specific to our membership. They're being offered in the counties and they're open to anyone who wishes to attend, but, yes, we will be notifying our membership of the availability of the classes.

CHAIR PARTIN: Okay. Great.

DR. HEISTAND: Any other questions?

MS. CURRANS: Could I back up to the ER visits? A 9.1% decrease in utilization in what year?

DR. HEISTAND: Year over year, the year ending in May of 2017.

MS. CURRANS: Could you just give a brief description of what those programs or strategies have been?

DR. HEISTAND: Those were in the presentation that we provided. So, the details are in that presentation.

Essentially, they are outreach opportunities to members who have had multiple Emergency Department visits, letters to providers which are probably not all that effective, quite

honestly. We have new mailers going out soon to members. We've done that in the past. We'll be doing it again. So, probably a host of opportunities.

MS. CURRANS: Can I ask if there has been work in correlation to how many with reoccurring ED visits have an underlying behavioral health need?

DR. HEISTAND: The number is quite high. I can't quote it for you, but we do believe that there are a significant number of recurrent Emergency Department utilizers who have at least some behavioral health diagnoses on the list.

MS. CURRANS: And, then, is there case management within your division?

DR. HEISTAND: Absolutely, yes. That's a specific focus. As relates to our readmission program, we are specifically working with individuals with coexisting behavioral health conditions to try to make certain that their hospital readmissions are addressed and needs are met.

MS. CURRANS: Thank you.

CHAIR PARTIN: Any other questions?

MR. MARSH: I have one question

having to do with the treatment of Hep C until Stage 3. And I understand that you're not capable in your professional opinion to answer that question, but who within Aetna is able to answer that question?

DR. HEISTAND: Again, this is a policy decision that is to mirror the State benefit plan.

MR. MARSH: That's not what I'm asking. I want to know what the rationale is to why you wait until Stage 3 to treat Hep C?

DR. HEISTAND: So, are you asking what the managed care decision process is in general?

MR. MARSH: I'm asking why you make the decision to wait until Stage 3. I don't know what the process is because that doesn't tell you an answer. I want to know why you choose or any insurer chooses to wait to treat Hep C until Stage 3. That's all I'm asking.

DR. HEISTAND: In summary, it has to do with the risk of progression and the cost of treatment. Essentially, the cost of treating everyone with Hepatitis C outstrips the capability of the health care system to support that process, considering the literature that does not indicate

that all members progress to chronic end-stage liver disease.

MR. MARSH: Okay. So, that's your answer.

DR. HEISTAND: That's the best I can give you.

MR. MARSH: Okay. Thank you.

MR. CARLE: Can I go back to the ED visit question?

DR. HEISTAND: Sure.

MR. CARLE: What type of education do you do with your providers related to avoidable ED visits because that's what you want to do try to do? There are valid emergency room visits.

DR. HEISTAND: Sure. Sure.

MR. CARLE: So, give us a sense, and I did pull out what was provided last time which is appreciated, but give the committee a sense for what you do to educate not only the providers but also the participants related to avoidable ED visits.

DR. HEISTAND: For the participants, it's simply education about what conditions would be considered emergent, what needs to be seen - chest pain, I think I'm having a stroke, those sorts of activities, education about

our nurse line, education about the fact that many providers have nurse lines where they can contact a triage individual for assistance.

With regard to education to providers, it's probably not as much of an education as it is of information and dialogue of what can we do. Is there an opportunity to have extended hours? Is there a need to have a triage call system?

I'm not certain physicians need much education. It's really more of a provider notification and a request to see if there's anything we could do to help facilitate that.

MR. CARLE: So, can you tell us any direct stats related to it says the CM outreaches its members with three-plus ER visits each month. The remaining members with one to two ER visits are sent an ER mailer. That's all well and good. You don't even know if they get it.

DR. HEISTAND: Correct.

MR. CARLE: And, so, what kind of success do you have on bringing down these overall ER visits and getting them into the urgent care setting or with their PCP?

DR. HEISTAND: At this point, I don't think I have--I don't have specific data to

those programs, and I think it's going to be a year or more before I do, to be honest with you.

MR. CARLE: All right.

MS. WATKINS: I have a question kind of related on the same line. Do you all have anything in place to where you all are looking at why those certain individuals are going back those three times?

I'm just curious as to do you have anything in place for like transition of care where you're looking at the comorbidities of the patients to where you're trying to keep the patients out of the hospital, maintaining their health so that they're not going back to the emergency room?

DR. HEISTAND: Optimally, we could have a programmatic, systematic mechanism to do that. At this time, it's really individualized. So, our case manager is defining a root cause analysis of reasons why folks are going to the ER. So, we have anecdotal, you know, descriptions.

One individual couldn't get her PA done with her provider for her chronic opioid. So, we talked with the provider and said how can we help you do this or do you realize this needs to be done, worked out, that was taken care of.

We have another member that was having some chronic abdominal pain and for some reason couldn't get into the specialist that needed to be seen. We fixed that in about thirty seconds.

So, I wish I could give you a description but they're all individualized. And, so, if we can come up with a systematic way to address, we'll be very grateful and happy about that, but right now it's individualized.

MS. WATKINS: Okay. Thank you.

CHAIR PARTIN: Anything else? All right. Thank you.

DR. HEISTAND: Thank you.

CHAIR PARTIN: Next up is Anthem.

DR. RUDD: Good morning. My name is Andrew Rudd. I'm the Pharmacy Director for Anthem. I'll be speaking on behalf of Anthem today.

The question that was asked was also around ER utilization and what Anthem is doing to decrease that.

Looking year over year from 2015 data all the way through the second quarter, 2017 data, in 2015, our total visits per 1,000 member months was 472. Looking at the total of preventable

ER visits was about 9.7%. And looking at the next year data, total visits decreased by almost 13%, about 413 visits per 1,000 members, and looking at the preventable ER was 7.5%.

And, so, we had effectively a 13% decrease overall and just over a 2% decrease for preventable visits to the emergency room.

A lot of this was accomplished through a multi-prong approach. A lot of it was case management telephonic outreach to members. Those were members that had three or more visits to the ER. And, so, that was marginally successful.

Another approach was that our members were mailed listings of urgent treatment centers in their area. And along with that list, they were also given a refrigerator magnet that had our nurse line number. So, they had that resource that they could call that nurse and get that initial information of should I go to the ER.

And, so, looking at that, the mailer and the urgent treatment center list, had about a 28% increase in visits to the urgent treatment center of those members who had previously been using ER for treatment.

So, that outreach, you know,

simply providing that alternative treatment source had an impact on where patients were going to receive treatment.

MS. CURRANS: Can I ask you a question about the preventable? Did you use the word preventable as a percentage? I just missed that part.

DR. RUDD: I did. From a standpoint of - and this is based on diagnosis code - it was 9.7% for 2015 and, then, the same data for 2016 was 7.5%.

MS. CURRANS: And is that diagnosis code the provisional or the final, based on the final diagnosis----

DR. RUDD: I believe it is based on final.

MS. CURRANS: ----after review of the patient and assessment or the provisional which is the reason the patient was brought in to the ED?

DR. RUDD: I'm not 100% certain of that. I believe it is the final, after the visit has taken place.

MS. CURRANS: Okay. Thank you.

MR. CARLE: That's some pretty

good success.

DR. RUDD: Yes. I think a lot of it is just giving the patient the resource to better find avenues of care and giving them--you know, essentially just empowering them to use the more appropriate side of care.

CHAIR PARTIN: Did you look at urban versus rural?

DR. RUDD: I don't have that data. I don't know if they did look at it. Looking at our top ER facilities, obviously the University of Kentucky, St. Elizabeth's and St. Joe's were kind of at the top of the list of where utilization was occurring.

So, with that being said, I think it's kind of concentrated to that particular area of the state where our utilization is occurring.

CHAIR PARTIN: Okay. Thank you.

DR. RUDD: If there aren't any other questions, I'll move on to our second----

MR. CARLE: Before you start, Veronica, I have a question, or Steve, because I just don't know this. There isn't any copay associated with visits to the emergency room in the MCOs,

correct, or is there?

MS. CECIL: There are copays associated with the service, but MCOs right now under the current contract can waive those copays if they so desire; but in terms of what we do in fee-for-service, there is a copay that is supposed to be utilized.

MS. CURRANS: But they are waived.

MR. CARLE: Correct. Thanks.

DR. RUDD: The second question was around quality care from the eye exam measures, I'm assuming around diabetic eye exams.

Essentially, Anthem provides education to our membership with a diagnosis of diabetes and that's handed out through individual mailings, as well as newsletters that the membership receives.

In April of this year, we initiated an adult value-added benefit where we were providing coverage for eyeglasses. So, members were now able to get eyeglasses. So, they were actually going to the eye doctor and being seen and being treated. And as a result of that value-added benefit, we have seen a significant increase in our

CDC retinal eye exam rate. So, the value-added benefit is having additional benefit outside of just providing eyeglasses for our membership.

MR. CARLE: Does that have to be performed by an opthamologist or can it be done by an optometrist?

DR. RUDD: I'm not 100% certain of that. I think that if they are----

AUDIENCE: It is optometrists.

MR. CARLE: Okay. Good. Thanks.

DR. RUDD: Any other questions?

MS. ROARK: I have a question. I see on here that you are also adding contact lenses.

DR. RUDD: Yes, ma'am.

MS. ROARK: That is a new one.

DR. RUDD: It's a choice between either contact lenses or prescription eyeglasses for members.

MS. ROARK: And how often are you allowed to go back to get lenses because they don't last as long as glasses, right?

DR. RUDD: Right. It is yearly, if I recall correctly.

MS. ROARK: Thank you.

DR. GUPTA: I had a question about the diabetic eye exam. Are you all offering any kind of other reward system? I've had a couple of patients I believe with Passport that if they have their eye exam, they get a reward.

DR. RUDD: I'm not certain that we have any other rewards.

DR. GUPTA: Like gift cards or anything like that.

AUDIENCE: No, we don't.

DR. RUDD: We do not.

DR. GUPTA: So, it's just the added benefit of the glasses which is great and contacts. Okay.

CHAIR PARTIN: Anything else? Thank you.

Next, Commissioner Miller.

COMMISSIONER MILLER: Good morning. It's already been said a number of times. It is a pleasure to look across and see your table to be full this morning. We haven't seen that for the past year. So, that's good for both sides of the table as well.

An update on the 1115 Waiver.

Now, some four months ago, as I recall, Chris Carle and I had the conversation as to did we expect it to be approved this summer, and we had some discussion at the time as to whether or not it would be approved by the end of the second quarter. In fact, I think we commented that at the end of the second quarter but by the end of June and we expected approval by that date.

Obviously, the calendar today reads September 28th, well outside the second quarter. So, no, we have not seen that approval yet. I'm as confident today as I was then that we will see approval in a very short time frame.

We have had CMS onsite this past week doing some of their due diligence as well looking over some of our systems, checking for readiness as well and getting a better handle as to how we will do what I call the back-room operations of the 1115. That meeting, that process went very well.

Clearly, what we are requesting is distinctively different than what we have seen across the country thus far in any of the 1115 Waivers. We have taken it somewhat to a little different level. The community engagement is

different than what has been requested in other states up to this time. CMS acknowledges that and is being very diligent about the process of the approval there, but, again, we expect that really at anytime.

In fact, I'm happy to entertain any questions there as it relates to that process on the 1115. I know you have some specific questions as it relates to some of the components and I'll bring what I call the experts on those areas to come up to address that as well.

MR. MARSH: Commissioner, what is the continuing impact on the state as it relates to the current Kynect program that's in place? Is it a significant impact in terms of financial costs associated with it or is it that the feds are still paying the bulk of the costs associated with it?

COMMISSIONER MILLER: No. My Medicaid costs continue to run in the neighborhood of $11 billion a year on average with the mix of a different population, be it traditional or expansion. Weighted, about 20% of that is actually state money, but the number of enrollees continue to go up. Today - you've probably heard this number before - we're at 1.4 million Kentuckians. One out of three effectively are now on Medicaid.

Back originally when the Medicaid expansion was done by Executive Order, the estimates or projections at that point in time was by 2020, that there would be approximately 188,000 people who would then be on Medicaid as a result of expansion. Today, that number is 472,000.

When we started down the road as far as looking at the 1115 Waiver, we were talking about some 440,000 individuals that were on Medicaid as a result of expansion. Again, today, that is 472.

So, to say what is the fiscal impact, it continues to go up. The number of enrollees continue to go up as well.

MR. MARSH: So, when does the match from the feds change again on the state? Does it drop back to the 70/30 at anytime or does it stay 80/20?

COMMISSIONER MILLER: On the expansion population, it never goes back to the 70--- under current law, it does not go back to 70. Let me rephrase that. Today, it's a 5% match the State puts up. It goes to 6 and then will eventually get to a 90/10 split.

For the current budget that we are in, the increase as far as us being the State

picking up the 5% was approximately $250 million of state money over an 18-month period and that number just continues to go up as we phase in the higher rates. And we're in the process right now of budgeting that for the upcoming Session as well to get a handle on what that impact will be.

Other questions before we get into your list?

CHAIR PARTIN: Anything? I don't think so.

COMMISSIONER MILLER: Medically frail, Dr. Gil Liu will address that.

DR. LIU: Thank you. Just a brief, kind of basic reminder about the 1115 Waiver. So, that is a funding mechanism by the Centers for Medicaid and Medicare Services for states to be innovative. It's very broad-ranging. It's meant to be a reform that is exploratory and experimental.

The really exciting components of Kentucky Health, Kentucky's 1115 Waiver, is that it ties more strongly than ever before economic reforms, individual-level job preparedness and health outcomes, and if you look at what's being increasingly recognized is that a person's socioeconomic status and their environment determines

more about their health than sometimes the quality of their clinical care.

When you pursue any 1115 Waiver, so, there have been recent waivers about substance use disorder. There are a number of states that are in the group with Kentucky looking at community engagement and cost-sharing.

Because of the experimental nature, you are required by CMS to define those that are medically frail and should be shielded from the experiment. Their health needs are so complex and so tenuous, if you will, that you can't experiment on their health care access. You need to identify those that need reliable, consistent, non-experimental access to health care and carve them out from the reform.

So, there have been a number of states again that have gone forward with 1115 Waivers of various types, and they have defined a body of kind of standard or best practices around identifying those that are medically frail.

One approach is that for those beneficiaries that you've had in your program for a period of time, you have information about their health utilization, their health diagnoses, and you

can enlist companies that have medical underwriting expertise to run an algorithm against your claims' data set in an automated fashion to identify probability of medically frail.

So, clearly we can do that. We can look at the diagnoses on claims, the drugs that have been dispensed, the number of times a person has been hospitalized, and with a high degree of confidence and using standard methods pull those people out.

The more difficult situation is when you have a new person enrolling in Medicaid, somebody that hasn't given you a body of information. Then, the standard best practice and something that I feel very comfortable with is that you get those people into a clinician's office and you rely on a health care professional to attest that they have a condition that would qualify them as medically frail.

Now, there are some set of criteria that are challenging. For example, two of those are a behavioral health concern or an impairment in activities of daily living.

The nature of the challenge is that it's hard to get in to a behavioral health expert in a timely fashion because the infrastructure

is growing and we're kind of catching up on building the health care system that we need to address an increasing burden of behavioral health concerns.

The second thing is that when you ask somebody about impaired activities of daily living, often a physician's visit is very brief. It's kind of hard to really have a clinician in a 15-minute office visit determine do you need help with hygiene, taking your medications, transportation, so on and so forth.

So, I just wanted to offer that we've done a lot of work looking at other states' experience, and that includes going on site visits to other states to look at exactly how they've worked with their managed care organizations, how they've worked with actuarial companies, the forms they use to have clinicians attest to a medically frail status.

Then we've worked with consultants and in-house expertise to kind of replicate the best of those practices here.

So, that's a quick overview. I'll pause for a moment and entertain questions, see what I need to clarify that I didn't communicate as clearly as I should have.

MS. CURRANS: Will part of the criteria be any absolute diagnoses, like let's say it's a Type I diabetic. Will part of the criteria just be specific disease states?

DR. LIU: So, there are some that are very straightforward. For example, if you are receiving Social Security Disability Insurance, that automates.

MS. CURRANS: Yes, that's an automatic.

DR. LIU: If you have severely impaired vision or a neuromuscular condition that clearly limits mobility, a complex genetic disorder, severe forms of cancer under active treatment with chemotherapy or radiation, those are examples of things that are easy to detect and that are kind of, I think, what fit into your example.

I would, though, take the example that you gave, Type I diabetes. So, a person with Type I diabetes can have relatively mild health concerns, be fully capable of benefitting from community engagement. I think many people with diabetes would be glad to have more appropriate employment and higher salaries.

So, the algorithm needs to be

sophisticated enough to look at their medical management. Do you require dialysis is a great example, a comorbidity of Type I diabetes, renal failure as an appreciated but rare or late-stage complication of diabetes that is readily addressed through the medical underwriting expertise that we have through our current actuarial contract.

MS. CURRANS: That's good.

MR. WRIGHT: Can I ask a question? You bring up a concept. So, my intent is to clarify the difference in compassionate allowances by SSI under Social Security and medically fragile because my concern is you bring up the concept of those who have genetic disorders, but many of those people do need services beyond an MCO offering and they need support for activities for daily living but there's extensive waiting lists for those services because they do meet the criteria under compassionate allowances of SSA but they don't have the access to the programs that meet their full needs. Can you speak to that?

DR. LIU: To a degree. I think first, what you are inquiring about is outside of the realm of defining people as medically frail for the purposes of the 1115 Waiver.

And I think you're asking about the more important issue. For those with really significant health concerns, are we able to deliver the services that they need through things like public health insurance and all of the federal funding and programming that is made available.

It's a recognized challenge that, through things like our Waiver Programs, there's a waiting list and that's problematic.

I would offer and this is kind of not the best venue, I think, to go into the depth of conversation that we need to have, but those also are being scrutinized actively by Medicaid and its managed care partners.

So, I'm very empathetic to your concern and the critiques of the degree to which we can meet the need. And I think, to echo something that Dr. Heistand said, you want to go the furthest you can with often resources that are quite constrained.

MR. SCHULT: Excuse me. I have a question. Of the population that would be eligible for these more experimental types of care under the 1115 Waiver, what percentage roughly are excluded because they are medically frail? Is it a sizeable

percentage that wouldn't be applicable or a smaller percentage?

DR. LIU: So, two things. First, the Kentucky Health Program is focused on able-bodied adults, and another way that's often said is the expansion population.

So, Commissioner Miller offered that number is approaching 500,000 right now. There are people who have been identified to have varying degrees of requirements under that. Women who are pregnant is one. Children is another. So, that's the first part of the answer.

The second is looking at other states' experience, and I think Indiana is instructive in that regard. We have similar topography. We're located in the same part of the U.S. The demographics of our Medicaid population are fairly comparable. And their medically frail population is about 10% of who is exposed to their HIP Program, the Healthy Indiana Program.

We have clearly designed in a period where we're going to be iteratively refining the approach to medically frail because we'll see who comes in under the first pass and then we'll need to look really carefully at kind of how we're doing by

getting input.

So, I think 10% is a good rule of thumb for us. We are at the epicenter of many new health concerns - opioid epidemic, Hepatitis C by virtue of abuse of illicit drugs, things like a risk of expanding HIV prevalence.

So, I think it's a moving target, but right now we're kind of for planning purposes and strategy looking at about a tenth.

MR. MARSH: You brought up Kentucky Health, and many of us, I'm sure, were in attendance at the hearing where former Congressman Ben Chandler did a presentation on Kentucky Health.

And obviously we as Kentuckians are a little disappointed that our health care in Kentucky ranks at the bottom of the barrel and continues to be that way.

Is there anything that is actually going on at the state level which is addressing the ways to overcome being the laughing stock of health care in this country?

DR. LIU: Well, the answer is of course.

So, I don't mean to be flippant in that regard. You're entirely correct. We've

watched the United Health state rankings that have been available now for well over twenty-five years and Kentucky has ranked on average 45th. I'm happy to say that the 2016 rankings, we ranked 39th.

And if you look at the domains of factors where health is kind of gauged - access to care, quality of services, environmental supports, health behavior - who knew health could be so complicated.

I think there's many things that make it challenging. Kentucky as a state with a population that has very poor health behavior is one example of that, among the highest rates of smoking in the country, among the lowest adoption of preventive services.

We have health services and delivery systems that compare unfavorably to their peer networks, among the highest rates of preventable hospitalizations, among the highest rates of ER visits for ambulatory care sensitive conditions that would much more appropriately and much more cost effectively be addressed in other settings.

If you look at the HEDIS measures which are a nationally endorsed set of health care quality metrics that we use to gauge the

performance of our managed care organizations, again, it's really concerning how little progress the delivery systems have made in partnership with managed care to do better compared to other similar health care systems in other states.

So, the 1115 Waiver is really promising again because it's well-recognized that socioeconomic status and employment have a huge impact on health. And those programs, economic stimulus, job training, health care services have often been solid. So, we're bringing those together much more tightly than ever before.

There's a long list of things that we're looking at - quality of care of the children under the CHIP Program, quality program through our Waiver Programs. So, it's hard for me to cover the landscape of that.

I appreciate your concern and I, too, when I look at the longstanding low ranking of our state, I think we need to really stop the status quo. And I feel comfortable saying we're making major reforms that have a lot of promise.

MR. CARLE: So, Dr. Liu, let me be more specific for Gary's question.

Let's just look at PCP visits.

So, as Commissioner Miller described, we had an overwhelming influx into the system with the expansion. How many of those 472,000 patients have actually had a PCP visit to establish that HCC rate so that you can put them into the frail or not frail category? Can you give us a sense for that because that's the beginning of the relationship for prevention and wellness?

DR. LIU: So, when we've looked at any evidence of primary care involvement, the number is about a third of that population.

I do want to temper that number. You know, what you see is when you have an expansion of Medicaid eligibility, it takes time to get to know who those new beneficiaries are.

So, what we've seen in multiple other states that expanded is in the first year, it's a wreck. The people that come in under expansion have very non-optimal health services' utilization. And I'd offer that you should extend some grace to the people that manage those beneficiaries to get them into care, to get to know what they need and then build that system.

MR. CARLE: And the managed care companies are doing that on the commercial side

and on the Medicare Advantage side because they are giving incentives to get these patients in for their annual wellness visit at the beginning of the year so they can ascertain where they are in their health cycle and then take care of it because their actuaries are telling them, and we all know this, the sooner you find it, the less it's going to cost to treat. So, to your point.

DR. LIU: The other thing I will just briefly add is then we went on to look at when they had a primary care visit, did they get the preventive services that would be recommended. And, again, the uptick is really, really low.

And the question then becomes, well, where do you pin the blame and I think it is, in part, it's a population that has a lot of challenges in adhering to medical recommendations, following through on the referral to get a colonoscopy, for example.

The second is that I think the health care delivery systems need to be much more proactive about coordinating care, managing cases, engaging their patients. And, then, clearly we're trying to do a very good job of partnering with our managed care organizations, are we collaborative to

be creative and to commit to moving a hard number. We have metrics on this now.

MR. CARLE: And, so, to that end, then, what is in the agreement with the MCOs and the Waiver moving forward - and, Commissioner Miller, Veronica, maybe this is something for you to address - that incentivizes those patients to actually get in and see a primary care physician?

I know we've got the credit system, if you will, or I forget what the actual term is for it, but what incentivizes the patient to actually do that?

COMMISSIONER MILLER: I would say at this point it's a number of different things; but before we go there, Gil, I just want to back up.

You've pointed out from the standpoint of what we have achieved or not achieved in years gone by and what the overall health status is of Kentuckians today, and I would say it cries out that we need to try something different, and that's what we're trying to do and intend to do with the 1115.

Whether or not it will be successful, time will only tell, but what we do know, how we have delivered in the past has not gotten us

to the results where we need to be. I've said at many, many different meetings, thank God for Alabama and Mississippi, and I don't like making that comment, but we've got to be able to move the needle and do things better.

Back to your question, Chris. From the standpoint as it relates to the MCOs, we're trying to hold their feet to the fire, for lack of a better term, for better outcomes and we've now been able to set up internally. We've not had the ability before to run those metrics that we need to do to be able to do that.

One of the items that we have done is that besides having our quality incentives, the HEDIS incentives that we've had in the past, and we're ready to move that needle to some other program as well, but through the 1115 and the new contract that will be in place as a result of that going forward because we're still working under the current old RFP, the old contracts. So, we haven't been able to dovetail all of that in yet.

We plan on and will do that for contracts effective 1/1 of '19. It sounds like a long way away but just from the standpoint of the timing to be able to get things done.

One of the other successes that I believe that we have been able to do and that is within the state as it relates to the profitability, some of the dollars that have been spent are not spent sometimes related to the delivery of medical care.

We have implemented that 90% MLR which is one of the more stringent in the country, that we are requiring those dollars be spent on medical care. If they're not, we will claw that back in the future.

MR. CARLE: But can you address the specific incentives related to incentivizing a Medicaid patient to get in and see the physician? Obviously there's a payment component that they didn't have before because now they have coverage, but what incentivizes the patient to actually go to the doctor and start that relationship? Anybody?

COMMISSIONER MILLER: Today we haven't been able to do that as it relates to the traditional Medicaid Program. Through our Rewards' system, we will be doing that, but today it is lacking.

MS. CURRANS: But very much needed.

COMMISSIONER MILLER: Very much needed.

One other item that I would like to add as we move on before Kristi comes up and talks about the Rewards, I said earlier about one of the successes.

Another success, at least from my view, was not quite a year ago, the gentleman sitting to my left agreed to serve as Medical Director for Medicaid. I think you can see why I asked him to do that and why I'm pleased that he said yes.

MR. CARLE: I would agree.

DR. LIU: I couldn't have a better boss to work for.

I just wanted to make a shout-out to the managed care organizations. They are offering incentives for uptick of preventive services. Gift cards are going out and other things. And you can see, again, it just points to what does it take to get this done, but I didn't want to diminish that they have taken that approach.

I'm going to yield the floor because we have the expert on the My Rewards Program.

CHAIR PARTIN: I have a

question first before you leave on the medically frail just to kind of sum it up so that I understand. There isn't a set definition. Is that correct? The definition is based on different diagnoses that the patient has except if they have Social Security Disability, cancer or chemo or they have a physical disability.

DR. LIU: Yes. Thank you for that clarification. So, the approach will be tailored to the Kentucky Medicaid population. Our actuarial service will look at all current enrollees and their utilization and define those that fit kind of well-recognized criteria.

So, the presence of diagnoses for different categories of severe disease has been done a number of times for other states.

There are new instances, and, again, those are behavioral health and impaired activities of daily living that are a little more challenging.

So, if you look at how we've had claims come in for behavioral health services, it's relatively under-developed because only recently was a decision made to transfer those as Medicaid benefits instead of State-supported mental health

safety net systems. So, our administrative data is relatively small.

So, in that regard, it's a little bit of a moving target.

CHAIR PARTIN: So, we don't have a set definition at this point.

DR. LIU: We have best practices from other states that define well-endorsed criteria in every aspect - physical health, behavioral health, activities of daily living, homelessness.

So, I do just want to make sure I'm communicating that the conceptual model, if you will, and the list of diagnoses is fairly well-formed, but what we need to do is really look at how that hits against the Kentucky beneficiaries and what we have in hand and that will also inform kind of what we ultimately decide on as criteria to include people as medically frail.

CHAIR PARTIN: Okay. So, we don't have a set definition yet but we're working on it except for these other criteria from other states.

DR. LIU: The prior experience of other states and existing medical underwriting guidelines gets us 98% there, and 2% of that work

should always be tailored to the state and its existing beneficiaries.

CHAIR PARTIN: So, that's the part we're still working on.

DR. LIU: Yes.

MR. WRIGHT: I might clarify the statement, too, because the Social Security Administration has the compassionate allowance criteria that's been vetted and documented and it has a list of disabilities that fall into that compassionate allowance criteria.

Have you looked at that because you can submit--you know, as practitioners, the states can submit for compassionate allowance in certain areas. I just was curious. My intent is just to make sure we're using a metric that has been already established, well-established and well-documented.

DR. LIU: I will be candid. I haven't scrutinized that list personally; but what I will say is that we have paid an actuarial consulting firm with the requisite medical underwriting expertise, and I am highly confident that they have looked and also have contributed to the development of those type of criteria.

COMMISSIONER MILLER: But I might add, that will be a question that will be asked on our next phone call.

MR. WRIGHT: Okay.

MS. CURRANS: Commissioner Miller, could I just ask kind of a global? If you found out tomorrow that the Waiver is approved, how long before you think it will be operational?

COMMISSIONER MILLER: Our time frame is to start phasing things in, start earning some right after the first of the year and will be implemented 7/1 of '18.

MS. CURRANS: So, 7/1/18.

COMMISSIONER MILLER: Yes.

DR. LIU: Than you all.

MS. PUTNAM: Good morning. I'm Kristi Putnam. I had the pleasure of speaking to this group the last time you met. I'm the Program Manager for the 1115 Medicaid Waiver Kentucky Health Project and I'm glad to provide some additional information on My Rewards specifically related to preventive services but I'm also happy to answer any questions before we get started with that.

MR. CARLE: I was particularly interested in what is the incentive for a new

enrollee to go and establish that relationship with a primary care physician that they might not have already had because they're over-utilizing the emergency room as their primary care physician, just to give you a little context.

MS. PUTNAM: Yes. And I did bring some draft information with me today. It's something that I will leave for you to take with you. I think at the last meeting, we went over some of the qualifying activities for the My Rewards Program but we didn't talk about any associated dollars or give you any idea of what we were talking about as far as incentives to be paid into that My Rewards' account.

As far as the incentives for establishing primary care, we do have several activities and several incentives to be paid into the My Rewards' account that relate to going to get that physical, establishing primary care, seeking a primary care visit after an emergency room visit so that they can continue the care and follow the recommended medical guidelines.

We also have a number of different My Rewards' incentives that are around preventive screenings, as well as child well care, so, taking your child for their immunizations for

their annual physical.

So, we are really trying to focus the My Rewards around preventive services. We've heard loud and clear from not just this group but also from dentists, optometrists, everyone who is concerned about that preventive care preempting the later, more expensive visits and the more serious health conditions.

Just to give you an example, for someone to go get their annual physical including a biometric screening, we have suggested, our My Rewards Subcommittee has suggested a My Rewards' payment into that virtual account of $100. So, we really are trying to incentivize the preventive services with a higher dollar amount.

Just to contrast that, going to complete some of the online courses, some of the health and financial literacy courses that we're including as part of Kentucky Health, they would still receive an incentive payment for that, but that would be at a $10 or $20 and some of them at a $50 level. So, the preventive services really have been recommended to be at a higher dollar amount.

Now, that being said, I would like to just update this group that part of the, I

think, thoughtful consideration that is happening at the CMS level is the fact that they are giving us expenditure authority for things that are new and different under the My Rewards Program.

We also have a question of budget neutrality that is being looked at with the dollar amounts that are being assigned to these incentive activities. So, we have to balance out the number of incentive dollars that are attributed to each of these activities with the actual cost.

When those dollars go into the My Rewards' account, they become expendable. The member can go ahead and use that My Rewards' account for dental and vision services, and we're still working on the fitness piece, too.

So, that is where we are. So, that is why I say when I leave this information with you, it is draft. We are working with our actuary for some recommendations on what these numbers should look like to make sure that we are not breaking the bank, so to speak.

MS. STAFFORD: Pardon me. Do you think the people that are receiving these rewards are aware that they are there and are they using them?

MS. PUTNAM: They're not aware yet. The actual spending wouldn't happen until July 1st of 2018. They will be able to start accruing rewards beginning in January. That's the first part of our implementation. Our roll-out starts January 1st. With payment first for My Rewards, they will get credit for those preventive services.

But to answer your question, part of our outreach is with not just our beneficiaries but it's also with providers. It's with other stakeholder groups. It's certainly with our front-line staff, our DCBS and Medicaid staff who are manning the phone lines so that everyone has the same information.

We're also working with our application assisters to make sure that they have the information that these My Rewards are going to be available.

And we're working with a number of different groups, and I think I spoke to that last time, to get additional suggestions for what kinds of activities and what kinds of preventive services should be added to this list of activities, of qualifying activities.

DR. RILEY: At present, do you

have a reward for the preventive dental visit or is there only a charge for it?

MS. PUTNAM: We have included a recommendation that the preventive dental visit and the preventive vision exam both are qualifying My Rewards' activities.

CHAIR PARTIN: I have a couple of questions related to this.

First of all, it seems like the participants are going to have to do like the preventive exam or some other things before they can get any reward dollars in their account to pay for an eye exam or a dental exam.

What happens if somebody has something urgent that they have to have taken care of, they have an abscessed tooth or something like that and they haven't had their preventive visit yet? And, actually, one preventive visit probably isn't going to be enough to take care of the dentist.

MS. PUTNAM: Right. Again, that will always come down to a provider will have to make the determination whether they're going to go ahead and treat and have a situation where there aren't enough dollars for the My Rewards.

We're still having those

discussions about whether the account could potentially go negative on a one-time basis for a situation like that. So, we are having those kinds of conversations.

It's our goal that by starting the incentives in January and by frequent and extensive outreach with all of our Medicaid recipients, that they will have enough dollars in their account starting July of 2018 and, then, it will be an ongoing outreach effort.

Our MCOs are very engaged in how they can help incentivize also and how they can help with the information outreach to members about qualifying activities and making sure that they are continuing to replenish those dollars as they use them.

CHAIR PARTIN: Okay. And, then, what about the retroactive recoupment of funds for providers? When a patient signs in and you validate that they have coverage and then all of a sudden, they don't have coverage and the provider is told that they have to pay back money, how does that affect with the rewards?

MS. PUTNAM: So, with the rewards and with some of the technology redesign

that's going into this, right now there is a screen that the providers go to to check the eligibility, and the My Rewards' information will also be available. They won't see the amount a person has. They won't see the balance, but there's going to be a prior authorization process for them to go ahead and prior authorize the My Rewards' account so that there's a 30-day period. They have the service. They've already checked eligibility and secured the funds through the My Rewards' account and they then have 30 days to submit that claim.

There's also going to be a feature in the new technology where, during that same visit, if a provider, for example - and I know this happens a lot - gets into let's say a dental preventive exam and discovers the need for a filling or something else, there's also the ability to change that preauthorization and increase the amount so that they can complete the additional services needed and they don't have to send the person away and have them come back. They can increase the amount of that claim.

They can also, if somebody cancels an appointment and they put a hold on the account, they can also cancel that amount so that the

individual doesn't have funds being held out that they could use otherwise.

CHAIR PARTIN: Right now what happens is that the providers validate the current coverage and it shows up online that they've got coverage, but, then, later on, the provider is told, oh, no, they didn't after all and you've got to pay us back. So, what happens there with the rewards?

MS. CECIL: She's talking about retro termination of eligibility, not just necessarily the utilization of the Rewards' funds.

MS. PUTNAM: Right, right, and that's something specific to Kentucky Health. And, again, that isn't something specific to Kentucky Health. With Kentucky Health, though - and correct me if I'm wrong, Veronica - but the retroactive piece goes away, or is that just for the coverage piece?

MS. CECIL: It's important to note that eligibility and CMS' requirements that we don't expend funds on people ineligible still apply.

I think from what Kristi is saying is what you need to probably understand is that if somebody comes into Medicaid new and they are under the Kentucky Health Program, there's no retro eligibility determination.

So, it's always going forward, but there is, unfortunately, always that risk that something happened. There's information we didn't get or it was wrong. You're going to always have those outliers with that kind of a system, that there are going to be people that may or may not end up being eligible.

CMS requires us to pull back those funds. We just can't expend funds on somebody who is not eligible. So, it will still happen. We continue to make improvements in our system and in our verifications of eligibility to prevent that kind of retro termination. So, we're hoping that we keep making that group smaller and smaller, but it will always be out there.

MS. CURRANS: Can I ask a question about rewards? Is part of the rewards a non-smoking environment for children? Will there be rewards for children?

MS. PUTNAM: Part of the rewards include smoking cessation activities. We don't have anything specific included in the non-smoking environment for children, although that's something we hadn't talked about before.

MS. CURRANS: Well, that

creates subsequent ED visits often for young children with reactive airway. I mean, it's just fairly consistent.

MS. PUTNAM: It does and it is something that we can add to the list of things to consider.

One thing I would like this group to know is that we've asked for a lot of things from CMS, but one of the big things we've asked for is flexibility around the My Rewards Program so that we have the ability to make adjustments and add and take away activities as we find they are effective or not effective so that we are not locked into one set.

And that's why when I say this is draft information, again, this is draft information and it's not the latest. We have an updated draft that I can share with this group later, but this is something that I wanted to have to all of you from last visit.

MR. CARLE: So, Commissioner Miller, could we ask that Kristi be in attendance at the next meeting so that we have the ability to review that and then can ask you some followup questions?

COMMISSIONER MILLER: I think

you just did.

MR. CARLE: Okay. Thank you.

MS. CURRANS: I'm still confused about the dental. With the current program, current expanded program, do they have dental coverage?

MS. PUTNAM: They do. They have dental and vision through their managed care organization.

MS. CURRANS: That's what I thought. Okay. So, then, with the Waiver Program, what changes for the able-bodied?

MS. PUTNAM: So, what changes for those who are in Kentucky Health for the primarily expansion is their dental and vision, similar to what state employees have - we have our health insurance and then we have a health spending account that we can contribute to for our dental and vision and other expenses - we're setting up a similar structure for Kentucky Health. And, so, their dental and vision will be part of that My Rewards' account.

The difference is they are not contributing monetary value to it. They are contributing through activities and qualifying

preventive services.

MS. CURRANS: But on day one, they won't have anything in a dental account.

MS. PUTNAM: Our goal is, because we're starting the accrual January 1 of 2018, our goal is that they will.

Now, that will be true of newly eligible members. When they sign up for Kentucky Health and they're new, they would not have an account or they would not have a balance in that account; but, again, that goes to the outreach and education and really to the incentivizing of the preventive services that this group is so supportive of.

DR. GUPTA: In regards to the vision, does that include the medical eye exam or is that just for a refractive diagnosis for glasses or contact lenses?

MS. PUTNAM: I'll have to check on that.

DR. GUPTA: Because typically the medical eye diagnoses we bill through the medical.

MS. PUTNAM: I'll check on that. I think that's right. I think it's the

refractory exam but I will check on that and have that ready for you at the next meeting.

DR. GUPTA: Okay. Thank you.

COMMISSIONER MILLER: Just to follow up on one comment that was made as it related to budget neutrality.

Through the 1115, honestly, our goal is to enhance the overall health and outcomes of Kentuckians. Through the innovative program and what we are attempting to do, one of the balances, one of the things that we need to be able to show to CMS and through this demonstration, we're not spending more money than we would have spent had we kept it the same way.

So, we're trying to come up with an innovative approach that will bring about better outcomes, better health status and not spend more dollars than what we're spending today. That's the budget neutrality factor that we have to live within.

MS. STAFFORD: What about the mechanism to use those funds that will be created or the incentives? What about the mechanism to get those in use?

MS. PUTNAM: So, there will be

an actual account associated with each individual, and this is not on a family basis. It's on an individual basis. There's no talk at this point of them having an actual card but they will have an account and that's where it shows up in the same place the eligibility shows up when the provider looks up that person's eligibility that they have an active My Rewards' account.

And that person's balance also will be available to them through the Call Services' line. They can call and check their balances or they can also go onto the self-service portal and they can log in and they will see what they have earned credit for, what they have been debited for and what their balance is, and that's through our MMIS system, our claims system.

DR. ROBERTS: Forgive me. I am new to this program, but as far as what you can spend the My Rewards' dollars on, is it exclusively at providers' offices or does it extend to DME, medical device companies or what are the limitations of spending that money?

MS. PUTNAM: Right now it's limited to the fee-for-service schedule. So, it's what is provided at the provider office or anything

else that's included on that fee-for-service schedule, the Medicaid fee-for-service, with the exception of the fitness activities and we're still working on being able to include fitness activities as part of the expenditures. We're working hard to convince CMS that fitness activities contribute to overall health and well being.

MR. CARLE: Commissioner Miller, this is kind of off the subject but germane. You kind of brought this up.

With regards to the RFP that you are still developing, are there any efficiency standards for the MCOs to meet?

The gentleman that was representing Anthem gave some really nice statistics related to what I call efficiency standards, how many ED visits per 1,000. There are national and regional benchmarks related to that.

Is there a component regarding that because I know with the contracts that we have, we being the hospital system, with our managed care organizations, we are incented to bring those numbers down and to be more efficient.

So, it's regarding ER visits, specialist encounters, readmissions to the hospital

and overall admissions to the hospital and overall admissions to our skilled nursing facilities. So, we're looking at those national benchmarks and trying to bring them down.

So, the long-winded question is, are we incorporating those types of incentives related to efficiencies onto the MCOs in the RFP so that they can work with their providers again to bring them down but they should live up to those same standards that the providers are living up to?

COMMISSIONER MILLER: I am comfortable in saying we will have additional metrics that will be part of that RFP, part of those contracts.

You used the term efficiencies. I would say outcomes, you know, somewhat the same in that we want to see the results to make sure we're all heading in the same direction. There will be metrics and expectations there.

MR. CARLE: Okay, because it was impressive again from Anthem to go from 472 ED visits per 1,000 to 413 in one year. Those are the kinds of statistics and metrics and outcomes that you would like to see as it relates to that.

So, if we could incorporate

something like that, that would be beneficial.

COMMISSIONER MILLER: We intend to have basically some quality incentives maybe a little different than the HEDIS Program as we know it today but have some sort of quality incentive in there.

MR. CARLE: Okay. And, so, we'll talk about that a little later because one thing that Beth and I have looked at that we'd like to maybe hand out to all of the committee is the Kentucky Medicaid Crosswalk for Quality Measures.

COMMISSIONER MILLER: Yes.

MR. CARLE: And, so, we'll talk about that under New Business but this was great to see.

COMMISSIONER MILLER: And we plan on making that as a presentation possibly at the next meeting.

MR. CARLE: Okay.

CHAIR PARTIN: Okay. Thank you. Anybody have any other questions for the Commissioner?

COMMISSIONER MILLER: We have one other topic, I believe, on your list to talk about, the mobile and remote technology. Veronica

Cecil will talk about that.

MS. CECIL: I think we have mentioned previously that the Department is undergoing a major deep dive into the current telehealth services benefit. Our regulation is ancient. It has not kept up with the times. We recognize that.

We have been working with the Telehealth Board, with other stakeholders in trying to and probably, as we generally do, look at other states and best practices and CMS and what is going on in this area and what can we do to revise the benefit related to telehealth services.

That is ongoing. And I know you all kind of get tired of hearing that, but the reality is, it is ongoing. I know the Governor just recently appointed some new members to the Telehealth Board and we're excited about that.

It is a Cabinet-wide effort that is being undertaken because it's not just Medicaid. I think there's an effort to move telehealth services in Kentucky not just related to the Medicaid plan but as a whole for insurance in Kentucky. So, we continue to work on that. We don't have anything specific to add.

Mobile is currently not covered. A mobile phone, I know, is sort of the up and coming, but we have talked to some experts about that type of service. It certainly is something that we're looking into to see how Medicaid could cover something like that.

Medicaid has a lot of requirements on it that other insurers don't have. So, we just have to make sure that it's in line with what CMS would approve.

So, we're making tiny, tiny steps towards proposing something. We will absolutely, when we get to a place where we've got a really good proposal because you've got to start somewhere, we get a proposal, we will definitely share that with the MAC. We'd love to get the feedback from the MAC on where we're going so that we can work together on the ultimate product.

MR. CARLE: Can we request, though, a presentation from the Telehealth Committee as to what the baseline is, what is offering now and what they are looking into?

MS. CECIL: Sure.

MR. CARLE: And, Commissioner Miller, you mentioned it before. Thank God for

Mississippi and Alabama.

Mississippi is making great strides related to their remote capabilities, as well as their telehealth specifically related to the treatment of diabetes and monitoring people's A1c's that are in rural areas that otherwise couldn't do it.

I know a lot of that has to do with the connectivity of the state, but that state has really put a premium on their connectivity throughout the state and how it applies to bringing down their overall health care spend.

I can give you a contact down there. It's a gentleman that used to work up at the Mercy System in Cincinnati that's now the president of the University of Mississippi Medical Center and they are reaching out throughout the entire state to accomplish this.

And you're right, Veronica. You've got to take baby steps, but that's what this state is going to have to do if they want to leverage technology to their advantage which we can.

MS. CECIL: And from what I can tell, and that's not just a Medicaid-focused initiative, right? It's something they're doing as a

statewide effort.

MR. CARLE: Exactly.

MS. CECIL: If you could share that contact with us, we absolutely will reach out.

CHAIR PARTIN: Can we put that on the agenda for next time?

MS. CECIL: Yes, absolutely. Just a couple of other things while the Commissioner has the table.

Open enrollment is beginning October 16th through December 15th. The materials are going out. It's on our website. I wanted to just continue to put that on your all's radar.

That open enrollment, for those of you who are not very familiar with it, is really only for being able to change your Medicaid managed care organization. So, it's an open enrollment to be able to move among the five MCOs that are contracted with the State.

Somebody does not have to wait for open enrollment to get into Medicaid. Medicaid is a rolling, always open when you're eligible, but open enrollment for Medicaid is just to be able to change your MCO.

CHAIR PARTIN: What's the date

again?

MS. CECIL: October 16th through December 15th.

COMMISSIONER MILLER: Just a side note, I don't like the term open enrollment. I don't think it describes what really takes place. We're trying to come up with a better term than that.

MS. CECIL: We also, I believe, passed out already and wanted to just bring to your attention, currently we have stakeholder meetings going on for our 1915(c) redesign. That's the Home- and Community-Based Waivers. Kentucky has six.

We're stepping back and looking at them all. Navigant is helping us with that initiative. Those are going on right now.

The point of it is for people to come and hear your story, what can we do better, where are the barriers, and everything is on the table for this redesign and we really want to be thoughtful in how we move forward with that.

And, then, the other list that you have that I think is stapled to that is the provider forums that we're going to be starting. These are our managed care provider forums that we normally had on an annual basis. We did not have one

last year but they're starting back up in October. So, there's the list of those dates and locations and the agenda, I believe, on the very back of that page.

MS. HUGHES: This is not in your binder. This is a separate, two-page document that was handed out right before the meeting started.

MS. CECIL: Thank you, Sharley.

MR. WRIGHT: In regard to the handout, thank you all. I respect that we had that and I know that was a topic we discussed at the last meeting.

One just quick suggestion. As I look through the list, the first thing I noticed is I didn't find the time. And, of course, I got to the back and I found it. A suggestion may be moving that time of the morning session and the afternoon sessions onto the front of the page.

MS. CECIL: Is that on the 1915?

MR. WRIGHT: On the 1915. It's listed as the very first thing on the back page, but just as I was thinking, where are the times, to just put it on the front.

MS. CECIL: What we did, that's not an actual handout. We just put that information

together for you all. On the website, it's all together, but I'll take that back in case we have it printed somewhere. Thank you. That's all we have.

CHAIR PARTIN: Thank you. So, we have an hour and five minutes left and we've got all the TAC reports plus the reports on substance use and Casey's Law and from two of the MCOs.

So, I'm going to ask as we go through these TAC reports, we have the reports. So, if you all would just quickly go through your recommendations so that we can get through everything in the meeting in the next hour.

Behavioral Health.

DR. SCHUSTER: It's bad that I get to go first again.

Good morning. I'm Dr. Sheila Schuster. I'm Acting Chair of the Behavioral Health TAC, and I will just tell you since there's so many new members that the Behavioral Health TAC is one of the newer TACs established in 2012.

We have representatives from the behavioral health community which is mental health, substance use disorders and acquired brain injury and those are our TAC members.

So, we had our meeting on

September 12th and we had five of our six members there. We had five MCOs represented and we had people from Medicaid and from the Department for Behavioral Health.

One of the issues that we looked at was the admissions and denials to what we call the Psychiatric Residential Treatment Facilities. Those re PRTFs. You all will remember that we talked at the last meeting about the number of children that are kind of stuck in psychiatric hospitals with no place to go, and one of the places that we're looking is what is happening with the PRTFs. So, we did get all of that information from the MCOs and we will be analyzing them.

I should also say that my report is not in your binder because I was bad this time around and was late getting it to you. So, it's a separate handout. It's a front and back, just white paper, and I apologize for that.

We also requested data from the MCOs regarding their authorizations for medication-assisted treatment for substance use disorders and we hope to have that for our November meeting.

We were very pleased to have Dr. Gil Liu who you heard from earlier come and talk

with us about the medically frail category. We in the behavioral health community are very concerned about how that determination will be made, and here are the things that we understand from Dr. Liu.

It will be made on the basis of claims data as it is reviewed with a specific analytic tool. There will also be attestations from clinicians that will be submitted for review.

There will be automatic inclusion in the category of those who receive SSI and SSDI, the length of time for which the determination will be made.

And this is a question we've asked over and over again because people get into recovery, particularly with substance use disorders, often with serious mental illness and we are wondering how that is going to work as people kind of rotate in and out of recovery and that's to be determined.

Some of these classifications will undoubtedly be for a lifetime. Others may be for as little as six months at a time.

We're concerned also about the notification of Medicaid members about their category. This is a really important category

because people that are in it do not have to pay premiums. They do not have to meet the work or community involvement requirements. And, so, for our people with these kinds of disabilities, this is really going to be critical, and there's a lot of anxiety out there among family members and consumers about who is going to be in that category or not.

There will be an appeal mechanism available, and we're still not sure how the definition of a chronic substance use disorder will be determined or made with regard to that category.

We hope to have Dr. Liu back in November. We're hoping that the Waiver will be approved by then. We've heard it was thirty days for about six months now and we hope to have him back. We really appreciate his openness to dialogue with our group.

Advocates and providers with individuals with brain injury continue to be concerned about problems in the regulations which we brought to you last time. We have several recommendations around that category of folks.

One is that DMS report on the status of the Neurobehavioral Unit which was to be a part of the Eastern State Hospital but we think

actually never happened.

We also recommend that a Crisis Stabilization Unit specifically for acquired brain injury be established. This is particularly needed when an individual with a brain injury is no longer successful in his or her current placement, is out of control and cannot return home. And parents, families, as you can imagine, are just desperate to try to figure out where these folks could go next for their care and treatment.

We also recommend that personnel care services be made more compatible to meet the needs of individuals with an acquired brain injury who also use a wheelchair, have diabetes, need feeding tubes, have significant contractures or other complex medical and physical needs.

And, finally the regulation that limits the number of hours that adult day treatment is open be extended into evenings and weekends. It would provide a true social opportunity for individuals when they want to access the community. Right now, it's pretty much restricted to an eight to five, five days a week.

We want to thank Medicaid for the issuance of Emergency Reg 907 KAR 3:066E

regarding non-emergency medical transportation. We now have that available to take our folks to the pharmacy, and you can imagine how important it is, particularly with your behavioral health patients that they get their prescription and be able to get to the pharmacy to get it filled so that there's no gap in the medication. So, we appreciate that very much. Thank you.

We also have changed the meeting. Our next meeting date, we decided we didn't want to meet on Halloween. No. Actually, it was because we didn't want to compete with the provider forum. So, we will meet on Wednesday, November 1st. Thank you very much.

CHAIR PARTIN: Thank you. Children's Health. Consumer Rights and Client Needs. Dental.

DR. RILEY: Dental met on August 23rd; but since we didn't have a quorum, we cannot forward recommendations at this time.

CHAIR PARTIN: Thank you. Nursing Home Care.

MR. TUMBO: We just wanted to thank the Department for their work on this clocks' change that's going on and transparency with all of

that. We appreciate the effort that is going into that.

CHAIR PARTIN: Home Health.

MS. STEWART: We met yesterday. One of the hot topics that we discussed was the labor-intensive effort to verify that physicians are active in the Medicaid Program. So, we had a healthy discussion on that and probably more to come.

CHAIR PARTIN: Okay. Thank you. Hospital Care.

MR. CARLE: I don't see the rep from the hospital here. So, I will go ahead and give that report.

The Hospital TAC met on September 9th and a quorum was present. The main discussion item was revision of the methodology for distributing DSH payments to hospitals. A statutory change will be needed in the next legislative session.

The KHA has worked with its members to update the methodology and presented its recommendations through the TAC to the Department.

They also had additional discussions with regards to the IMD exclusion related to mental health, and Sheila has talked about this

also in the past.

Previously, the Hospital and Behavioral Health TACs have formally recommended to the MAC that the Department immediately implement the new CMS rules that allow states to pay for up to fifteen days of care per month for an adult Medicaid patient in a freestanding psychiatric hospital.

And there's a hearing going on right now over at Budget Review simultaneous to this meeting with regards to this.

The TAC also discussed several issues related to the MCOs. The TAC was informed that hospitals need to file complaints with the Department regarding MCO payment issues in order for the Department to assign penalties for corrective action.

Some hospitals have not done this because they have not known this methodology and they were holding monthly MCO meetings to discuss this. So, that will be rectified moving forward.

Lastly, the TAC members expressed concern and frustration with a new Aetna policy. Inadequate notice was given as a fax was sent dated September 1st stating that on the same date, there would be a new process for unlisted

codes.

The Commissioner requested a copy of this Aetna communication. Aetna has since rescinded this policy, but the fact that it was implemented without any discussion with providers plus the time and manner in which it was communicated was very concerning.

That's it. Thank you.

MS. HUGHES: Chris, could you send that to me, your recommendations?

MR. CARLE: Yes. I thought they already had and I'll make sure that you get a copy.

MS. HUGHES: Thank you.

CHAIR PARTIN: Intellectual and Developmental Disabilities. The Nursing TAC has not met. Optometry.

DR. COMPTON: We met on September 7th. All the MCOs and their subcontractors and DMS were there and we had a quorum but we have no recommendations at this time, and the next meeting date is yet to be set.

CHAIR PARTIN: Thank you. Pharmacy TAC. Physician Services.

DR. GUPTA: We did meet last

month but I do not have the report. I'll have it submitted after.

CHAIR PARTIN: Thank you. Podiatry. Primary Care.

MR. BOLT: David Bolt on behalf of Chris Keyser, the Chair of the Primary Care TAC. We did meet on September 14th and a quorum was present.

We essentially reissued some of our previous recommendations since we really have not gotten a formal response yet.

Primarily, the feedback from our providers is we need to move a little bit further on the wrap reconciliation. While we do understand that the Department is working very hard on auto-posting capability, that will be a godsend when and if it gets done and will relieve a lot of extra manual work that providers are having to go through.

I want to skip one. We brought up quality, a discussion on quality at our previous meeting back a couple of months ago. And I just want to say something to the Commissioner and his staff.

We really appreciate the effort and the partnership that they have created, and the Cabinet, in really defining what quality should be

and how it should be approached, how it should be measured, and we look forward to working with the Commissioner, his staff and the Cabinet on that.

We think, too, and it goes to an actual recommendation, we think a similar approach ought to be taken with risk-scoring adjustment where it is consistent among all payors and a process that is compliant, not that we're saying they're not compliant now, but a compliant-consistent process amongst all the managed care organizations.

We still wait a modifier for non-face-to-face encounters. That has been under discussion. We've had two false starts where DMS has said we're going to use this modifier and then we find out HP says no. So, we really think somebody ought to talk to HP and tell them to find a modifier.

We talked a little bit about the centralized credentialing that's being discussed. And, again, we want to emphasize a much earlier recommendation we made about, yes, credentialing is an issue but loading credentialed providers to a par line is probably more of an issue and often confused as the problem as opposed to credentialing itself.

The organizations we work with have delegated credentialing. That's done monthly.

Where we see the problem is in the load time. We did recommend ten days; but for my MCO friends in the room, I'll settle for fifteen.

We did talk about a couple of licensure issues where licensure for community health centers and rural health clinics currently in existence in the state are much more stringent in a couple of areas than federal guidance at this point.

For example, with RHCs, the requirement now from the federal level and CMS is that a provider only needs to be onsite once every two weeks instead of every week.

They have begun to recognize the fact that electronic medical records, telephones and video conferencing can work just as well in providing the necessary roles there and with the other requirements which was a good idea in 1973 when it was put in the regulation that every provider at a licensed primary care center be on courtesy staff or active staff at a hospital.

But with the advent of hospitalists in the last twenty years and agreements with hospitals to take care of inpatient needs, we think that should be brought in line with what the current federal guidance is.

CHAIR PARTIN: Is that one of your recommendations?

MR. BOLT: Yes, ma'am. That's in there, too. Thank you all. And it's really awesome to see this. Thank you all very much. This means a lot to those of us out in the weeds having you all here, and I'm very, very impressed with the discussion and the questions, even from Chris. Thank you all.

MR. CARLE: Hold on, before you leave, since you went there. You opened it. Where are we with the licensure issue? That obviously has to go to the State Licensure Board but where are you with that?

MR. BOLT: We had an OIG rep at the TAC meeting and they said they had the ability to have more stringent licensure regulations, and we don't debate that. The thing we're seeing, though, in a lot of rural areas and inner-city areas with the shortage of primary care providers we have, this creates a problem.

And having a physician or somebody else on staff at a--and we've got forty counties now without hospitals. So, in order to be an active staff member at some facilities, the

physician would be traveling thirty, forty, fifty miles in some instances. So, we think that's important from that perspective.

And, again, the same thing with the rural health clinics where the physician now by federal CMS guidelines only has to be there every two weeks. Again, that can be done via video conferencing or telephone and it's allowed under CMS rules.

So, we're just asking for your all's support there. We're not going to kick the can down the road. We're going to kick it upstairs and move on it because it's important to the membership.

MR. CARLE: Thank you.

CHAIR PARTIN: Thank you. Therapy Services.

MS. HUGHES: Beth was not able to be here today. Her letter is in here. And also I forgot but Pharmacy is in here also.

CHAIR PARTIN: Okay. Since we have the reports in our binders, we will consider those recommendations as part of the meeting.

We have forty-five minutes left. Let's go to the presentation on substance use disorder and treatment and Casey's Law.

MS. SLUSHER: Hello. I'm Koleen Slusher. I'm the Director of Behavioral Health of the Department for Behavioral Health, Developmental and Intellectual Disabilities.

MS. DICKINSON: I'm Tanya Dickinson. I'm the Director of Program Integrity Division at Behavioral Health.

MS. SLUSHER: And you should have a copy of a PowerPoint. We'll try to be cognizant of time since we're running out of it right now.

If you flip to the first page, it kind of gives an overview of the Department which shows the Divisions that fall under the Department for Behavioral Health.

So, the Division of Behavioral Health - and my name is right under there - it covers Adult Substance Abuse, Prevention and Promotion, Children's Behavioral Health and Adult Mental Health Services.

So, the Department oversees the state and federal funds that serve these areas for treatment in the Commonwealth, and we work to build on resiliency in people in the community who have these issues that we help treat and we facilitate

recovery for people who are affected by mental illness, substance abuse and disabilities.

The Division of Behavioral Health is responsible for the administration of state- and federally-funded mental health and substance abuse treatment services throughout the Commonwealth, and treatment, support and oversight services are achieved with the assistance of the Branches that fall under this Division.

So, if you flip to the next page, there is a map that identifies the different areas, including the acute care hospitals such as Central State, Eastern State, the immediate care facilities, specialty clinics which assist people who have developmental and intellectual disabilities. There are three of those in the state.

There are residential substance abuse programs identified on the map and a personal care home which is Central Kentucky Recovery Center which is on Eastern State Hospital's grounds.

There are three long-term care facilities. And, then, in the bottom right-hand corner, it lists all of the CMHC's that we work with - there are fourteen - and in partnership with the CMHC's, we provide the treatment services that I just

described.

The CHMC's, as examples of what are provided, crisis services, diversion services, services for adults with serious mental illness, children with serious emotional disorders, substance abuse, DUI, pre-admission screening and resident reviews, homelessness services and prevention.

So, the next slide just identifies the four areas which I described as Adult Mental Health, Adult Substance Abuse, Treatment and Recovery, Prevention and Promotion, and Children's Behavioral Health.

Due to our time limitations, I will just focus on Substance Abuse and Prevention because those tend to fall together. All the Branches work together collaboratively. Clearly, there's overlap in Branches and the services that the Division oversees.

So, the focus is evidence-based practices that focus on promotion, treatment and recovery services. The Adult Substance Abuse Treatment Branch is composed of several special initiatives and programs that I will talk about as time allows.

We oversee the federal

substance abuse block grant funds that are distributed to community mental health services to provide services statewide, and they use evidence-based practices which are required to ensure that CMHC's are providing quality treatment services to clients.

The staff work with the CMHC's to improve the process of collecting data on clients served and establishing outcome measures.

In the Prevention and Promotion Branch, they use targeted evidence-based prevention strategies for the reduction in rates of alcohol, tobacco and other drug use and abuse and suicide.

With state and federal funding, some prevention services are provided through contracts with community-based providers and partnerships with community agencies and coalitions.

General prevention strategies consist of community-based processes and environmental strategies, education, problem identification and referral, and alternative strategies are provided through the fourteen regional prevention centers which are connected to the community mental health centers, are housed in the community mental health centers, and, then, of

course, the other two Branches.

Your next slide has the prevention categories on it. I'll give you a brief overview of those.

The regional prevention centers are what I just mentioned that are housed in the CMHC's. They are staffed by certified prevention specialists. They engage in universal, selective and indicated prevention strategies. Their primary goal is to shift community norms that support unhealthy and illegal substance abuse by citizens. They work with and on behalf of all ages and developmental stages.

Some of the evidence-based programs that they use are called Prime for Life, Truth and Consequences, Making Healthy Choices and Zero Tolerance.

The policy and practice approaches include smoke-free ordinances, more responsible retail advertising of tobacco and alcohol, and school and local government policies aimed at reducing youth access to substances.

There are five subject matter experts on the prevention strategies involved with alcohol, tobacco, marijuana, substance-exposed

infants and faith-based communities.

In terms of suicide prevention, they work to develop a comprehensive system of strategies to reduce the number of Kentuckians who die by suicide. The zero suicide initiative works to create a fully functioning system of care for Kentuckians who have suicidal ideation through completed suicides from a prevention/intervention perspective.

And they use something called Sources of Strength which is an evidence-based, youth-driven, resiliency-based program in the schools.

And another area is the Youth Empowerment System which is youth groups working on substance use prevention and they also focus on gambling prevention.

Your next slide talks about specific substance abuse initiatives. So, one of the intervention areas is pregnant and parenting mothers. And the first one on your slide there is KY Moms Maternal Assistance Towards Recovery.

And this purpose is to decrease harm to mothers and children from use during and after pregnancy and it supports community mental

health centers in providing Medicaid reimbursement for case management and prevention and it goes two months post-delivery.

The next one identified that comes after that is called S.M.A.R.T.S. and it follows the clients for two years trying to get them involved in treatment and get their needs met.

The other area is Neonatal Abstinence Syndrome and, then, it identifies some specific programs starting with the Chrysalis House.

Other interventions include the continuum of care including residential, transitional and intensive outpatient programs. And in the parenthesis there, those are our community mental health centers that help to meet those needs.

On your next page, the interventions are continued and it just mentions what some of those are, so, the narcotic treatment programs including methadone clinics.

There's an expansion of medication-assisted treatment and driving under the influence. So, there's a big DUI program where people go and they're court-ordered to get DUI assessments and treatment needs.

And, then, the military focus

which is service members, veterans and their families, and under that are some programs that are overseen, including Operation Immersion, Operation Headed Home and, then, each CMHC has a military behavioral health specialist located in their facility to meet the specialized needs of the military and their famlies.

On the next page is Recovery Support, and the first one on there is Cooperative Agreement to Benefit Homeless Individuals which here is the CABHI grant and it has to do with homeless veterans or other people who are affected by homelessness who have SMI or a substance use disorder or cooccurring disorders and helping them to find housing and their needs being met.

Oxford House, it's a self-sustaining housing mechanism where patients, after recovery, as part of their recovery, go in and live together and pay their bills and sustain housing for themselves.

Supported employment and tobacco cessation also fall under Recovery Support.

Other areas include workforce development. So, there's peer supports which CMHC's are trying to use in all areas of recovery for the

communities, and the Annual Kentucky School which was just held this past summer and has to do with education and providing presenters to benefit community providers.

Then there is the Kentucky Prevention Network, Prevention Academy and the Providers' Clinical Support System for Medication-Assisted Treatment.

On your next slide, the next three focus on KORE which is the Kentucky Opioid Response Effort and this falls under the State Targeted Response to the Opioid Crisis Grant. It's funded by SAMHSA through the 21st Century CURES Act and it's a two-year formula grant with the first year being $10.5 million.

So, the point of this, the purpose here is to have a targeted response to Kentucky's opioid crisis by expanding access to a full continuum of high-quality, evidence-based opioid prevention, treatment, recovery and harm reduction services and supports.

The last sentence there talks about the highest-risk geographic regions of the state and the highest-risk populations. And, so, those regions are Louisville, Lexington, Northern

Kentucky and Eastern Kentucky.

The KORE Grant on the next page talks about how it includes prevention services which again revolve around evidence-based youth programming, naloxone distribution and drug take-back and disposal.

In terms of treatment as it referenced on the previous page, expanded access to medication-assisted treatment and bridge clinics which have to do with coming in to a hospital and immediately being bridged over to the services that you need to continue your treatment, and, then, recovery which has a big emphasis on peer support specialists, the training that they need, recovery support groups, supported housing and employment.

On the next page, it talks about coordination of agency contact. So, clearly one of the areas of intervention here would be bringing all of these people together which, of course, would be BHDID and the Department of Public Health, DCBS and OIG which would cover KASPER and, of course, Medicaid, Justice and Public Safety and AOC and Department of Education, so, bringing everyone together to address what the needs are for the community.

And, then, the very end here, we wanted to touch on Casey's Law. So, as of September 25th, there have been 221 petitions filed, and this came from the Administrative Office of the Courts. And assistance is provided by the County Attorneys' Offices to have these petitions filed as needed and they're filed to the District Court.

And I assume you guys know, but the law became effective in Kentucky in 2004 and it allows the parents, relatives or friends of an addicted personally to lawfully intervene for involuntary court-ordered treatment for a substance use disorder.

So, I know that was a lot of information.

CHAIR PARTIN: This is a lot of information. How many people are being reached by all of this? How many people are accessing this kind of assistance?

MS. SLUSHER: Through all of these services?

MS. DICKINSON: Or Casey's Law specifically?

CHAIR PARTIN: Through the services.

MS. DICKINSON: I don't think we have an entire number of everyone receiving them because they are received through so many different locations.

We can get and bring back some reflected data for you but this encompasses everything from community mental health centers to hospital facilities that are operated by the Department, facilities that we provide technical assistance to but we have no operation and oversight. We would want to define pretty carefully what kind of group we're talking about.

CHAIR PARTIN: Okay. I guess I just wanted to get a sense of are we reaching people? I mean, this is a lot of information and you went through it quickly, and I understand we've got a time crunch, but I guess the idea was to inform us of what's available but also inform us as to if people are really able to access these services and if it's a benefit. We hope it is.

MS. SLUSHER: That's part of what we were talking about with outcome measures and trying to see how many people are accessing services and the efficacy of those services. So, certainly if there are specific areas, we can report back.

The one thing that I didn't say that was in my notes here is we do serve over 800 clients that are served daily in inpatient facilities and those would include the facilities that Tanya just mentioned which would be hospitals, intermediate-care facilities, long-term care facilities and that's on a daily basis; but if you're looking for more specific populations served by these specializations, we can do that.

MS. CURRANS: Can I ask a question about Casey's Law----

MS. SLUSHER: Yes.

MS. CURRANS: ----we've had in my rural community. One of the concerns is because, a friend, for instance, can petition, but, then, there's always questions about who becomes financially responsible. Can you answer that?

MS. SLUSHER: The way that we understand it is that the petitioner is responsible for those treatment costs, so, that evaluation, the followup treatment and the transportation as well.

MS. CURRANS: So, the friend.

MS. SLUSHER: Yes.

MS. CURRANS: The petitioner.

MS. SLUSHER: The petitioner,

right.

MS. STAFFORD: I have a question about Casey's Law as well. I'm sorry. Did I interrupt?

DR. SPIVEY: I do, too. So, go ahead. I'll go after you.

MS. STAFFORD: The judgment and order for involuntary treatment, is that in-house and/or an office type thing? Can they do that treatment as far as does it have to be a residential place or can it be a doctor's office? What does that cover?

MS. DICKINSON: There's a list of providers, and I'm not sure that I could say definitively that it has to be inpatient or outpatient. There's going to be an assessment that's going to have been done to determine what level of treatment the person is going to need.

We can also get back with you specifically, but we didn't prepare a whole lot of depth and detail since it's not usually a Medicaid-related service. These are folks who are self-pays. So, it's not covered by Medicaid.

MS. STAFFORD: Okay. Thank you.

DR. SPIVEY: I have a question about Casey's Law as well. So, you said there were 225 petitions filed.

MS. DICKINSON: There were 221 that there were judgments and orders for involuntary treatment for fiscal '17----

DR. SPIVEY: That had actual orders for treatment?

MS. DICKINSON: ----that was provided by AOC.

DR. SPIVEY: But you don't have any examples of what that treatment consisted of for them?

MS. SLUSHER: You mean whether it's residential or non? Is that what you meant based on that question?

DR. SPIVEY: Yes.

MS. DICKINSON: There's a list of approved providers. I think it's on AOC's website. We can access that for you.

DR. SPIVEY: So, on that website, it tells like--I kind of wanted something more specific than that. I understand there's a list and I am familiar with that, but I just was wondering more of an outcome base as to what happened. I don't

want to know who they were. I want to know specifically what happened. What kind of outcomes did this law provide? Obviously, the petitions were successful but was the treatment successful? Is it working? That's what I want to know. Does that make sense what I'm saying?

MS. HUGHES: Tanya, do you all actually administer this program or is it through AOC?

MS. DICKINSON: We do not administer the Casey's Law program. We may have some involvement or some oversight with some of the programs that are providing services under a Casey's Law order but not as a specific program that is tracked.

And when I contacted the Administrative Office of the Courts for data from them, they were concerned about how much they were going to be able to provide to me. So, my suspicion is that they don't administer it like a program either. So, there's not going to be that ready access to outcome data for people who were under an order.

They might have people successfully released from petitions but I hesitate

to guess what AOC could provide. They were concerned about what they could provide.

DR. SPIVEY: So, they haven't provided data of who was released from the petition?

MS. DICKINSON: I didn't specifically ask for that. I asked for how many orders had been granted for the fiscal year.

DR. SPIVEY: Thank you.

MR. WRIGHT: Might I ask a question about the KORE program as well? That's a two-year formula grant that is a sizeable amount of income. I wanted to know what the outcome measures might be related to that as well, specifically the metrics for that program and who is monitoring those metrics?

MS. DICKINSON: We're just beginning the KORE grant. We've just received it and are in the process of putting out awards to programs. We're just getting ready to put out funding dollars to programs to deliver services. Dr. Katie Marks is the Project Director for that. And, so, we've not really been able to publish--there's been no results yet to publish.

There are significant metrics that are required by SAMHSA to collect. And as the

programs start going forward, there will be a lot of data that will come from that.

MR. WRIGHT: Process data, informative, summative.

MS. DICKINSON: Absolutely. That's a national effort. So, it will be comparable across states.

MR. WRIGHT: Is there a sizeable amount of human capital that has to come into that project as well, putting people on the ground in certain locations?

MS. DICKINSON: Yes and no. Ten million dollars divided across the whole state is not really a whole lot of money and most of it is going to be done through agreements with local providers, existing local providers. And, so, some of them will hire additional staff and that's going to be absolutely required. Some of that will fund treatment beds for individuals.

MR. WRIGHT: Thank you.

MR. CARLE: How about the expansion of the MAT programs and where are they located?

MS. DICKINSON: They're listed on here, I think.

MR. CARLE: I have no idea where Pennyroyal is or Four Rivers.

DR. SCHUSTER: Pennyroyal is Hopkinsville.

MR. CARLE: Okay. How are they doing?

MS. DICKINSON: They have just started receiving some funds about two years ago. Your Substance Abuse Branch is closer to it but I know that we're getting back good information from them and that they are expanding services and making more beds available and that's been the biggest push is to increase the bed space and the referral amount.

MR. CARLE: I was under the impression a lot of those were outpatient for MAT.

MS. DICKINSON: I'm sorry. That was a great answer for NAS.

MS. SLUSHER: Are you talking just in terms of expansion?

MR. CARLE: Yes.

MS. SLUSHER: I don't know the exact numbers. We can get them in terms of where it was and where it is now in terms of percentages of increase.

MR. CARLE: Okay. And, again,

we're looking for measures and outcomes and how effective is it. We're expanding one in Northern Kentucky that's going to be open probably I think in the next few weeks and we've had some really, really good success with this. So, it would just be nice to know how it's going throughout the state.

MS. SLUSHER: Sure.

CHAIR PARTIN: So, just these centers are the only ones doing that - Pennyroyal, Four Rivers, NorthKey and Comprehend? Those are the only ones that are doing it?

MS. SLUSHER: That's the information I have, yes.

MS. DICKINSON: They're the only ones that we're funding. There are a number of programs that have applied. I know anecdotally that we've had some additional applications for methadone treatment programs that have applied to us but----

CHAIR PARTIN: Those are the only ones that----

MS. DICKINSON: That we have some oversight of as a funding source.

CHAIR PARTIN: Okay.

MS. ROARK: I would like to add to the Casey's Law. I'm a mother that did the

Casey's Law and I have my daughter in the audience today. She is a survivor. You was asking questions about the payment and the success.

I hear not everything is good but it saved my daughter's life. You're talking about I went to the courts and petitioned. She was in danger to herself and others and she had to have a psychiatric evaluation; and at the time, she had a medical card that paid for this.

They told me that the Casey's Law was expensive. You can't afford it. I wasn't out any money. I'm blessed. And I took her to Harlan County, and the minute I called and told them I had Casey's Law, they took her immediately.

I'm on a Casey's Law Facebook page and I read about the success stories, and I appreciate you all coming today and touching on the Casey's Law. I've been waiting a couple of months for this to take place.

We have a big epidemic of substance use, but I'm happy and proud to say today that my daughter is sitting here.

CHAIR PARTIN: Does anybody else have questions? Thank you, Peggy, for bringing this forward and asking us to do this.

MS. ROARK: I appreciate you all. Thank you.

MS. SLUSHER: I just wanted to add really quickly that there is a recovery rally in the Rotunda today at 1:30 for Recovery Month. I just wanted to bring that to everyone's attention.

MS. ROARK: Yes. I thought about attending that, too.

MS. SLUSHER: Thank you for your time.

CHAIR PARTIN: We've got two more presentations and then we've got some New Business. Humana.

MS. STEPHENS: Hello. My name is Cathy Stephens and I wanted to say thanks for the opportunity to present today. We always look forward to these opportunities and your feedback.

Humana-CareSource has been in the Kentucky Medicaid Program since 2013. We have about 145,000 members and we have partnered with CareSource to administer our Medicaid Program and I think that may be common knowledge. I just thought I would go over it for those of you that are new.

We are really, really proud of our strong, comprehensive network of providers. We

work hard and have traditionally had a strong network and have built on that to have more Medicaid-focused providers as well.

The other thing we're really proud of is that we have assisted 995 providers in obtaining their Medicaid certification. So, we're very proud that we're able to partner with providers and get them into the Medicaid Program and assist them in that process.

Our state network includes over 20,000 dedicated providers. So, as you can see, it's a strong network.

We did a high level list for you on this slide of what makes up that 20,000. So, that's something that we are proud of and we continue to work on.

And along with having a strong provider network, that comes with making sure you have strong provider relationships. So, in the last year, we added to staffing to make sure that we improved our provider rep to provider ratio.

We're also very proud of our provider portal. Just a few things. It allows providers to complete electronic claims submission and it's at no cost. So, they can come onto our

portal and complete those at no cost.

We also enhanced the provider portal this last year to have improved member eligibility view by adding the disenrollment information as well. And, of course, our provider portal has many links and a lot of information out there to support the needs, of what the providers need and get them information and ways to find out what they need to know.

The other part of that is throughout the year, we provide education for our providers in various forms. We have provider forums. We have webinars. Provider reps go out and give guidance and answer questions and provide education. We also have packets and various information we share with them throughout the year. We've also included a list of our provider reps and their contact information by region.

Any questions on what we've covered so far?

We partner with Avesis for our Dental Program, and Dr. Caudill is here today to tell you a little more about that.

DR. CAUDILL: I'm Dr. Jerry Caudill. I'm the State Dental Director for Avesis,

Incorporated which is a Guardian company.

As stated, Avesis is the Dental Benefits Administrator for Humana-CareSource. And I believe it was previously mentioned last year at the MAC that when Humana-CareSource switched to Avesis, their dental network size approximately doubled. And I'm happy to report that since then, we have increased their network an additional 10% as we continue recruitment.

Regarding the Humana-CareSource adult Medicaid enhancements, while the DMS fee-for-service fee schedule allows only one adult cleaning per year, Humana-CareSource decided to match the two visits per year allowed for children and we're allowing that for adults. This also maintains the one visit every six months as is seen in the commercial world.

Humana-CareSource has also chosen to pay 100% of the current DMS fee-for-service fee schedule for both restorative and surgical procedures.

To further promote the Kentucky Triple Aim goals, Avesis made important grant awards during 2016. Avesis granted $30,000 to the Big Sandy Community and Technical College in Prestonsburg.

This grant was in support of the Community Dental Health Coordinator Certificate Program.

This is the first program of its kind in Kentucky and only the third in the nation, thus putting Kentucky on the leading edge of dental case management in America. This ADA-developed program trains dental hygienists and social workers to become community outreach dental case managers, and Big Sandy noted that this program would not have happened without this grant. While case management is nothing new to the medical world, this is entirely new territory for dentistry.

Our second grant was for $20,000 to the Red Bird Mission Clinic in Southeastern Kentucky. This grant was used to purchase an entire portable dental clinic, including dental chairs, lights, autoclaves, x-ray equipment and other equipment that allows not just screening or cleanings but also basic fillings and extractions.

The Red Bird Clinic has partnered with the University of Louisville School of Dentistry who will be supplying additional manpower to treat patients in this promise-zone area.

I actually spoke with the Red Bird Clinic this morning and the program is now in

full swing visiting senior citizen centers, nursing homes and schools.

Finally, Avesis participated in the February 3rd Give Kids a Smile screening blitz in Louisville. Avesis covered one-third of the entire cost of the program, working with the University of Louisville Dental School. Avesis supplied four of our field staff providers, three of which are licensed dental hygienists.

While we were there at the school, and there were six elementary schools involved in this blitz, not just screenings were provided but oral health education was provided to approximately 3,000 Louisville elementary children.

Avesis continues working on out-of-the-box initiatives for integration of care. So, stay tuned.

MS. STEPHENS: Any questions? We're going to move to pharmacy, and we have our Pharmacy Director who is going to share our pharmacy.

DR. VENNARI: Good afternoon. My name is Joe Vennari. I'm the Pharmacy Director for Humana-CareSource.

We're looking at a new opioid approach for acute pain. What we're going to be

looking at is limits on morphine equivalent dosing for short-acting agents. The max dose per day would be 60 per Rx. So, that is to say if you have a patient on Tramadol and Hydrocodone, each prescription would be okay for 60 morphine equivalent dosing.

Limits on short-acting agents for opioids would be also employed. We would be identifying new patients, looking at claim history, less than a 90-day supply over the last 120 days and this would be an accumulative approach where, again, if you had someone on Tramadol for three days and Hydrocodone for three days, that would be six days of those. That would be counted as six days.

PA's would be employed for any supply greater than seven days and a PA also would be required for greater than fourteen days in a rolling forty-five days.

And, of course, we would also have - I don't believe it's here - but a PA for morphine equivalent dosing being requested of greater than sixty.

A PA will also be available where medical necessity to prescribe opioids exceeds the limits, and we also employ exemptions, being

cancer, palliative care, end of life/hospice care, sickle cell, severe burn, traumatic crushing of tissue, amputation and major orthopedic surgery.

MR. CARLE: Define major orthopedic surgery. Hip replacement? Knee replacement?

DR. VENNARI: Correct.

MR. CARLE: Okay. That's part of that?

DR. VENNARI: Correct.

MS. STEPHENS: We know it's a strong focus for everyone right now and wanted to share our approach with the MAC today.

MS. CURRANS: And, then, there are appropriate secondary lines of medications that you all have on your Formulary.

DR. VENNARI: Yes. Thank you.

MS. STEPHENS: Next we'll have Kristen Mowder speak to our case management and our quality.

MS. MOWDER: Good afternoon. I'm Kristen Mowder. I'm Director of Care4U. With that, I'm our Director of Behavioral Health and over quality.

What you will see on the first

slide is over the past year, we have done a transition from our traditional case management program to what's called our Care4U population health model.

So, in the traditional case management programs, what you typically see is that top 1% of the highest cost members are the ones that are case-managed. So, they are the top utilizers, the sickest of the sick. It's clinically-based and typically engaged in the health care setting.

So, what we have looked at in our Care4U model is a more population health-based process. So, as you can see on that second tier, we have tiered out our whole population because we want to touch every member.

So, if you start down at the bottom, you will see that we have a self-management of the members. And, so, with that self-management, we've implemented some programs.

In the commercial world, you have Vitality. So, in our world, what we have is what's called My Health. It's similar to what you see in the commercial world where you have assessments, different kinds of education that you can go through online. You can take our health risk

assessment, different things like that.

I'll go ahead and talk in this space as well. There's a future slide about what's called My Strength. My Strength is a behavioral health tool that is similar. It's an online tool that members thirteen through adulthood can access. When they sign up for that, they have an individualized page. They can take the assessments of that. So, it's focusing on depression, anxiety, substance use, some different topics like that.

There's also articles, daily devotionals, quotes, things like that that they can access.

There's rating skills within it as well similar to what you see in your typical pain scale, the faces where you have the frowny face all the way through the smiley face.

So, they track how they are feeling in the day, and that could be a tool that's used as they go to see their PCP or other providers where the PCP can look and see a tracking of how their mood has been throughout time.

The second tier that you will see is called rising risk. That's 5 to 15% of the population. We call that episodic. There's also a

transitional outreach. So, those are the members that are, through our analysis, that they're healthy but they may have something going on that could possibly bump them up to a higher level. And in that, that transitional outreach piece is where we have case managers that monitor those members who are in hospitalization or in a facility and we provide outreach and coordinate care once they are post-discharge.

The next level you will see is a one-to-one care coordination. So, that's 1 to 2% of the population. That's more around those social determinants, things that the social worker type position can help the member navigate through systems and navigate through other resources in the community.

And, of course, that top .5% is that complex case management. So, those are the high-intensity members that you would typically see.

On the next page, you will see more in depth about the population health model. So, when you start the model, we have our population health risk identification. That's done through a John Hopkins ACG Program where they bring in all of our claims, all of our information, analyze it and

spit out what the member's risks are.

Humana-CareSource has as well a proprietary program that brings in those social determinants. So, we assign those social determinants and vulnerability scores to our member and then we put them in what we call population streams.

Our population streams that we have set are maternal child, behavioral health, chronic conditions, acute care and then the healthy individual.

Then you go down to the triggers. So, we monitor data for trigger events that may identify additional risks, needs and challenges to the members. So, in those triggers, we're looking at the socioeconomics, the coordination of care and clinical aspects. And, then, that feeds back into that level of care or that triangle that we had just talked about.

So, next, if you go to the next page, you will see our care coordination concept. So, that's part of that population health model that we just discussed.

So, we have a community-based and member-centric model. We integrate everything -

physical health, behavioral health - and we use those analytics to understand prevalent medical, social, behavioral health needs and access to barriers.

So, one of the things that we've done is add additional layers of staff in this model as well. So, you traditionally have your RN case managers. In our previous model, we had social workers but they were more as a resource so that if the RN had to get some kind of resource in the community, whether food bank, something like that, they would a one-off with that social worker.

In the new model, we call them 1:1 care coordinators and they are assigned members just as the RN case managers in that second tier that you had seen.

The next layer that we've added are called community health workers. You may have heard them being called in other areas navigators or something like that, but those are individuals that are located throughout the community. They do that face-to-face contact with our members and can assist them with the community resources as well.

We talked about the behavioral health pieces.

So, if you want to flip ahead

to the commitment to our members. There are several member stories in here but I will just go over the first one and then you guys, for the sake of time, can read through the rest of them.

The first one is about there was a family that had a one-year-old member that was hospitalized. The mother was pregnant. The family was homeless. The father had lost his job during this time and they had no means for transportation.

So, our case management team worked with this family, helped them secure appropriate housing, worked with local resources to find them furnishings for the house, worked with the items needed for the newborn because in this time the second child was born, and assisted the parents in arranging that transportation for the medical needs.

So, through all this work, we fast forward and check in on the family. One year later, the father is employed. They have stable housing. They have no food insecurities. Their bills are all current and they have a healthy, happy newborn and toddler.

So, if you want to move to the ER rate improvement slide. So, we give you a year-over-year trend. This is ER rates per 1,000 starting

with our 2014 data that we had through our 2017 data. And as you can see over the four years, we have had constant improvement. So, we went from 860 per 1,000 in 2016 to 738 per 1,000 in 2017.

In 2016, we completed an ER PIP that we had running. Some of the efforts that we've done to improve our rates are targeted case management.

We've recently looked at what we call census tracks and that's in Region 3, so, that's one of our most populated areas - that's that Louisville and surrounding-county areas - and we looked at our high ER utilizers.

And in that, we started out looking at our homeless population and, then, through the analytics, we dug down and noticed that in that population, there was behavioral health and substance use needs in that as well.

So, one of the things that we're doing is we're partnering with Centerstone. We're in the early developments of getting the business agreements and the IT work done to be able to securely pass information.

What we're looking at is through our ER claims and that inappropriate

utilization of ER plus there's behavioral health needs and substance use needs, the plan is to provide that information to the community mental health center. Then they will take those members through their homeless outreach and will try to find those members and help engage them in appropriate treatment; the other members, possibly put them in their targeted case management treatment and other programs that they have.

The next slide we have quality and health care outcomes. So, this is based on our HEDIS. So, as you can see from 2015 to 2017 trends, we have steadily increased our HEDIS numbers as well.

So, for 2017, we had a number of 86 measures that we improved upon. So, that was 61% of the total reportable measures improved for 2017.

So, our health outcomes improvement activities, we have member incentives for prenatal, postpartum and well-child visits. We have direct and indirect telephonic outreach for well child, lead screenings, dental prevention, prenatal and postpartum visits, diabetes and asthma care, and, then, metabolic screenings for the SMI population, and, then, smoking cessation for pregnant women.

We also have a tool on our portal called Clinical Practice Registry and that's in our provider portal. So, what that is is when a provider logs into our portal, they get their panel but they can also download their gaps in care. So, for each member, they can see when their member is coming in what gap in care they have related to the different HEDIS measures.

Next and I think our final slide, we talk about our NCQA accreditation status. So, NCQA recently completed their annual review of our HEDIS data for 2017, as outlined in the 2017 Standards and Guidelines for the Accreditation of Health Plan for Humana-CareSource.

And based on that 2017 results, Humana-CareSource was awarded a commendable status. That is an excellent accomplishment that we are very, very proud of.

And, then, also the last part of the slide, you will see that we align our quality strategies with the Institute of HealthCare Improvement Triple Aim strategies. Any questions?

MR. CARLE: I think the Anthem reps are still here. How many covered lives do you have in the Anthem programs for the MCO in Kentucky?

DR. RUDD: One hundred and twenty-seven thousand.

MR. CARLE: One hundred and twenty-seven thousand. So, Humana-CareSource, you have 145,000.

MS. STEPHENS: Correct.

MR. CARLE: So, they reported their ED visits per 1,000 is 472 and down to 413, and you've seen some really nice improvement but you're at 738. I want to make sure that we're comparing apples to apples.

So, we might have to talk to the Commissioner and Veronica and the team to make sure that these are an apples-to-apples' comparison because, again, this is where a lot of the cost is, but it's nice that you have that trend line going down.

MS. STEPHENS: Absolutely.

MR. CARLE: It's a very nice presentation.

MS. STEPHENS: Thank you. Any other questions? Thank you again for giving us an opportunity.

CHAIR PARTIN: Thank you. Passport.

MR. FELIX: Good afternoon, members of the Council. My name is Carl Felix. I'm the Chief Operating Officer for Passport.

DR. McKUNE: And I'm Dr. Liz McKune. I'm the Director of Behavioral Health for Passport Health Plan.

MR. FELIX: And let me apologize in advance. I'll try to provide as much brevity as possible.

On your slide that you've got is what we call The Passport Difference and I would like to call a couple of things to your attention.

Number one is Passport started out as a demonstration project twenty years ago. So, when we start talking about waivers, that's not a new concept. We are provider-sponsored. We are non-profit and mission-driven.

What I really wanted to depict on this particular slide was the fact that we have a Commonwealth-wide presence, both from a community engagement perspective and from a provider representative perspective so that we consider ourselves high touch. And from that perspective, we want to make sure that we try to encompass all the major regions in which we have business.

We opened an office in Prestonsburg initially to provide some economic stimulus there; but with the onset of Kentucky Health, we're actually strategizing the ability to change that particular facility to have more of a member touch point.

On your next slide, you will see the market share. We have 24% of the market in Kentucky. You will notice in Region 3 where we historically started business is where we have a large portion of that population, and in the other regions throughout the state, we range everywhere from 9 to 12%. Questions so far?

Our provider network. We have over 26,000 providers in our network. We've doubled that network since 2014. And over the last three years, our behavioral health provider network has grown sixfold.

If you look in your appendix later at your own leisure, you'll find we have some more detail in terms of how that particular growth by specialty is categorized.

On page 5, this really just shows the claims that were processed throughout that month. We process approximately 431,000 claims on a

monthly basis and about 650,000 pharmacy claims. If you look at the average, our average over 2016 was actually 99.99% in sixty days.

On page 6, one of the things that we started in 2016 was to begin to socialize the concept of value-based contracting. Primarily, initially, our goal is to do this with primary care providers because they are a touch point and Passport utilizes a medical home model.

So, we do assign all our members to a primary care physician, but our challenge has been, even though they are assigned to a primary care physician, that their access to care in terms of seeing those primary care providers is still a challenge.

So, we wanted to focus on creating a value-based strategy model specifically with some of our high-volume primary care providers, and we started that process back in 2016.

We socialized that with some of our high-volume primary care practices that are in our network and are beginning to actually modify it some of what we consider the metrics to support that process.

And, then, also our intent is

to roll that out for a 1/1 date in terms of actually beginning an upside on the arrangement with some of our large primary care practices because we all understand that from a fee-for-service perspective, we can't continue along that paradigm and, one, we have to share with our providers some of the limited resources that we have from a financial perspective and also reward them for their ability to deliver effective health care to our membership.

On the next slide, you will see come categories. One of the things we found in our conversations with our primary care providers was we wanted the approach to do not only pediatric coverage, adult coverage, but also how do you deal with those blended practices.

And one of the modifications that we made in the categories of prevention and quality was allow the ability to have these blended practices have measures that support both of those populations, and this was a direct result of our collaboration with our primary care providers in coming up with these metrics.

Am I going too fast? Right on time? All right.

I'll let Liz talk about our

partnership with Centerstone.

DR. McKUNE: On Slide 8, we have a slide depicting our value-based contract with Centerstone. We have partnered with Centerstone of Kentucky in Louisville to work with our population of members who have severe mental illness. As you may know, members with severe mental illness die on average twenty-five years sooner.

And, so, the model that we're putting in place is one that Centerstone has used in other states where they have put case management in place that also addresses the medical needs of these members at the same time and tries to drive the members toward their primary care provider.

So, at this point, we plan to serve around 300 of our members altogether and we'll be looking at different types of outcomes. And through this process, we have tied payments and incentive to the outcomes for the members based on the results of this pilot.

And, so, this was just executed in June and we look forward to seeing if approaching care differently with members will result in better outcomes.

MR. FELIX: On Slide 9, we have

a strategic partnership with Evolent Health, and one of the reasons we entered into that partnership was the ability to leverage technology to help us both from a perspective of more holistic care from a population health perspective but also the ability to really give us the opportunity to create systems and processes that would make us a differentiator in the Medicaid market.

That is what we do. We partnered with Evolent for the ability to get some more technology and things that we were not capable to do on our own. And from that perspective, we believe that this is our holistic goal of creating a Medicaid Center of Excellence but that's something that we strive to on a regular basis.

On Slide 10, when we talk about quality care, we also were reaffirmed by the NCQA as commendable for 2017.

And if you look at some of these measures here, you see that we have been commendable for the last two years in a row and that is the way that we want to ensure that we continue to service both HEDIS measures as a way to attain that certification, but the underlying goal is to make sure that we can get more quality at the point of

service.

DR. McKUNE: On Slide 11, we begin to talk about some of our programming that has gone on in order to better address the needs of our members.

We have looked through our analytics at different gaps in care plus through talking with our providers and through our behavioral health committee where we have had members participate, as well as advocates to give us feedback on where we might want to address some of the gaps in services at this point in time.

We have implemented a couple of pilots thus far that I will share with you on the next page and we're in the process of evaluating the outcomes of those.

So, on page 12, the first pilot that we have listed here is our Foster Care Pilot. This is where we have worked very closely with the Department for Medicaid Services, the Department for Behavioral Health and the Department of Community-Based Services to create a pilot in which we could drive resources to a child within their setting to hopefully prevent another disruption of a placement, so, children that are at risk of disruption because

of their behavioral health needs.

At this point, we are in the process of evaluating those outcomes. We served 57 children through this. I can tell you right now that we know that statistically we saw that there was improved functioning in the children, that their behavioral health needs, as well as their overall health needs and their social needs were better met through this model.

We're still in the process of determining the specific factors of the children that may have impacted that that could impact policy change going forward.

We're currently in discussions. We're looking at a Foster Pilot 2.0 in which we would build upon this and begin to address some of the children that have been in decertified placements in facility-based settings.

Also on this page, I took a moment just to describe our Out-of-Home Care Team and those are our dedicated specialists that work with providers, as well as our governmental partners and guardianship members and foster care members in the community to address gaps in care.

So, if a claim has gotten hung

up somewhere, they drive and chase that down because we know that with these members, due to the fact that they are in out-of-home placement, a lot of times, there is room for errors to occur.

The next page, we talk about our emergency room utilization. In 2013, we implemented an ER lock-in program, as well as ER navigator and coordinator programs.

We currently have embedded staff in three of our largest hospital-based facilities at this point. We also have some individuals based in our homeless shelters to do outreach as well to address some of these members who are using the ED as their primary care location.

In 2016, we outreached to 2,116 members and about 139 of those referrals went on to behavioral health as well.

So, we have implemented an Emergent Care Program in our case management software program to allow us to assess our members and document outcomes.

On Slide 14, we speak some to what we are doing with regards to the opioid crisis. In 2014, we were selected to participate in the Association of Community Affiliated Plans (ACAP):

Substance Use Disorder Collaborative.

We worked with sixteen other plans across the country to look at how we could better meet the needs of our members with opioid use disorders, and we worked on selecting our project for this as the SBIRT, so, through a primary care setting doing screening, brief intervention and referral to treatment. Since we have implemented SBIRT, we've had over 37,000 members screened for substance use disorders.

We also were selected as a plan to participate in the Center for Health Care Strategies and Conrad F. Hilton Foundation Learning Collaborative for Improving Access to SBIRT for Adolescents.

So, two of my team have been in Philadelphia all week this week working with other health plans across the country to look at how we can increase the number of screenings of adolescents, what can we do to reduce barriers and incentivize providers in order to conduct these screenings so that we can build relationships; and if members at some point do want to discuss their opioid disorder, that they would see their primary care practice as a safe place to do that.

In addition, we have our Opioid Crisis Management Program highlighted and this kind of speaks through what we have done in terms of our pharmacy interventions to address the opioid crisis.

MR. FELIX: And, then, the last thing I'd like to talk about for a second is our Go Noodle Program.

We partner with several hospitals that offer Go Noodle Plus at over 13,000 elementary school classrooms. The program uses technologies to get kids moving.

We actually partner with those facilities, and what they will do is take structured breaks that in lieu of just having the kids, it gives them an opportunity to kind of exercise.

During the 2015 and '16 year, we achieved over four million minutes of activity thanks to that Go Noodle video and the support that we provided to some of our partners.

They also use Mega Math Marathon and scores were 50% higher than those kids that were not using the game. We think this just highlights some of the different dynamic programs and we're pretty proud of the Go Noodle Program.

And, again, I apologize for

going through this at a thousand miles an hour, but hopefully we were able to cover all the information. We'll gladly take any questions that the Council may have.

MR. WRIGHT: Just real quick. My daughters love Go Noodle or whatever it is. They've done it in school. They have special needs and they love it.

MR. FELIX: Thank you.

MR. CARLE: And I like to see your approach to value-based contracting. That's what I was referring to before in the RFP. We need to be consistent with that type of approach with the RFP coming through in '18.

MR. FELIX: Yes, sir. Any other questions from the Council?

CHAIR PARTIN: Thank you.

MR. FELIX: Thank you. It was our pleasure.

CHAIR PARTIN: Last on the agenda, we touched on this a little while ago, the Medicaid Crosswalk for Quality Measures, and Chris is going to talk about that.

MR. CARLE: Veronica, if we could just bring this to the group maybe next time,

the Crosswalk.

My biggest concern which, after researching, there are consistent clinical care indicators in that. We want to make sure that they are consistent with the existing type of MCO contracts, the indicators about diabetes, breast cancer screening, colorectal screening, diabetes eye exam, nephropathy, controlling high blood pressure, and use of imaging studies for low back pain.

When I say consistent, we want to make sure the definitions are consistent across the board because what happens a lot of times is Aetna has a different definition than Humana has than Anthem has.

In looking through this, it's the same definition that Medicare has right now which is perfect. So, kudos to whoever put this together.

MS. CECIL: Yes. It was a fantastic team that I can say I was not on that took over this initiative with working with the Secretary of the Cabinet who she actually was really kind of pushing this.

The plan for that is to implement that in a future MCO contract to ensure the consistency. We're moving from HEDIS, our HEDIS

incentive program and HEDIS scores to this program. So, it will be consistent among the MCOs.

MR. CARLE: And from a provider perspective, you want to make sure, again, those definitions are the same so that you don't have fifteen contracts and fifteen different definitions of what an A1c is.

MS. CECIL: Yes, sir.

MR. CARLE: Thank you.

MS. CECIL: We did present with the Secretary at a conference recently and we were going to take that and provide that information to you all and then kind of do a shorter version of that and a presentation and we can do that at the next meeting.

CHAIR PARTIN: Great. Thanks. So, that includes everything on our agenda.

Just a reminder, email me if you're interested in running for one of the positions so we can put you on the ballot for the next meeting.

We have gone through these presentations rather quickly. So, if you have any questions about those, email those to me so that I can put that under Old Business on our next meeting and we can get some answers to the questions.

MR. CARLE: And the next meeting is?

MS. HUGHES: I believe the next meeting should be the 16th of November. It will be the third Thursday because the fourth will be Thanksgiving.

CHAIR PARTIN: Anything else? Motion to adjourn.

MR. MARSH: Motion.

MR. WRIGHT: Second.

CHAIR PARTIN: We're adjourned.

MEETING ADJOURNED